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## **STEERING COMMITTEE ON BIOETHICS (CDBI)**

**Draft Recommendation Rec (...)  
of the Committee of Ministers to member states  
concerning the protection of the human rights and dignity  
of persons with mental disorder**

**and**

### **Draft Explanatory Report**

This draft Recommendation, which was approved by CDBI, has been transmitted to the Committee of Ministers of the Council of Europe with a view to the adoption of the draft Recommendation.

It is accompanied by a draft Explanatory Report prepared under the responsibility of the Secretary General of the Council of Europe.

**Draft Recommendation Rec (...)... of the Committee of Ministers to member states  
concerning the protection of the human rights and dignity  
of persons with mental disorder**

**Preamble**

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members, in particular through harmonising laws on matters of common interest;

Having regard, in particular:

- to the Convention for the Protection of Human Rights and Fundamental Freedoms of 4 November 1950 and to its application by the organs established under that Convention;
- to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (“Convention on Human Rights and Biomedicine”) of 4 April 1997;
- to Recommendation No. R (83)2 concerning the legal protection of persons suffering from mental disorder placed as involuntary patients;
- to Recommendation No. R (87)3 on the European Prison Rules;
- to Recommendation No. R (98)7 concerning the ethical and organisational aspects of health care in prison;
- to Recommendation 1235 (1994) of the Parliamentary Assembly of the Council of Europe on psychiatry and human rights;

Having regard to the work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment;

Having regard to the public consultation on the protection of the human rights and dignity of persons suffering from mental disorder, initiated by the Steering Committee on Bioethics;

Considering that common action at European level will promote better protection of the human rights and dignity of persons with mental disorder, in particular those subject to involuntary placement or involuntary treatment;

Considering that both mental disorder and certain treatments for such disorder may affect the essence of a person's individuality;

Stressing the need for mental health professionals to be aware of such risks, to act within a regulatory framework and to regularly review their practice;

Stressing the need to ensure that persons with mental disorder are never emotionally, physically, financially or sexually exploited;

Conscious of the responsibility of mental health professionals to guarantee, as far as they are able, the implementation of the principles enshrined in these guidelines;

Recommends that the governments of member states should adapt their laws and practice to the guidelines contained in this recommendation;

Recommends that the governments of member states should review their allocation of resources to mental health services so that the provisions of these guidelines can be met.

## GUIDELINES

### **Chapter I – Object and scope**

#### **Article 1 – Object**

1. This recommendation aims to enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment.

2. The provisions of this recommendation do not limit or otherwise affect the possibility for a member state to grant persons with mental disorder a wider measure of protection than is stipulated in this recommendation.

#### **Article 2 – Scope and definitions**

##### *Scope*

1. This recommendation applies to persons with mental disorder defined in accordance with internationally accepted medical standards.

2. Lack of adaptation to the moral, social, political or other values of a society, of itself, should not be considered a mental disorder.

##### *Definitions*

3. For the purpose of this recommendation, the term:

- “competent body” means an authority, or a person or body provided for by law which is distinct from the person or body proposing an involuntary measure, and that can make an independent decision;
- “court” includes reference to a court-like body or tribunal;
- “facility” encompasses facilities and units;
- “personal advocate” means a person helping to promote the interests of a person with mental disorder and who can provide moral support to that person in situations in which the person feels vulnerable;
- “representative” means a person provided for by law to represent the interests of, and take decisions on behalf of, a person who does not have the capacity to consent;
- “therapeutic purposes” includes prevention, diagnosis, control or cure of the disorder, and rehabilitation;
- “treatment” means an intervention (physical or psychological) on a person with mental disorder that, taking into account the person’s social dimension, has a therapeutic purpose in relation to that mental disorder. Treatment may include measures to improve the social dimension of a person’s life.

### **Chapter II – General provisions**

#### **Article 3 – Non-discrimination**

1. Any form of discrimination on grounds of mental disorder should be prohibited.

2. Member states should take appropriate measures to eliminate discrimination on grounds of mental disorder.

## **Article 4 – Civil and political rights**

1. Persons with mental disorder should be entitled to exercise all their civil and political rights.
2. Any restrictions to the exercise of those rights should be in conformity with the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder.

## **Article 5 – Promotion of mental health**

Member states should promote mental health by encouraging the development of programmes to improve the awareness of the public about the prevention, recognition and treatment of mental disorders.

## **Article 6 – Information and assistance on patients' rights**

Persons treated or placed in relation to mental disorder should be individually informed of their rights as patients and have access to a competent person or body, independent of the mental health service, that can, if necessary, assist them to understand and exercise such rights.

## **Article 7 – Protection of vulnerable persons with mental disorders**

1. Member states should ensure that there are mechanisms to protect vulnerable persons with mental disorders, in particular those who do not have the capacity to consent or who may not be able to resist infringements of their human rights.
2. The law should provide measures to protect, where appropriate, the economic interests of persons with mental disorder.

## **Article 8 – Principle of least restriction**

Persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.

## **Article 9 – Environment and living conditions**

1. Facilities designed for the placement of persons with mental disorder should provide each such person, taking into account his or her state of health and the need to protect the safety of others, with an environment and living conditions as close as possible to those of persons of similar age, gender and culture in the community. Vocational rehabilitation measures to promote the integration of those persons in the community should also be provided.
2. Facilities designed for the involuntary placement of persons with mental disorder should be registered with an appropriate authority.

## **Article 10 – Health service provision**

Member states should, taking into account available resources, take measures:

- i. to provide a range of services of appropriate quality to meet the mental health needs of persons with mental disorder, taking into account the differing needs of different groups of such persons, and to ensure equitable access to such services;
- ii. to make alternatives to involuntary placement and to involuntary treatment as widely available as possible;
- iii. to ensure sufficient provision of hospital facilities with appropriate levels of security and of community-based services to meet the health needs of persons with mental disorder involved with the criminal justice system;

iv. to ensure that the physical health care needs of persons with mental disorder are assessed and that they are provided with equitable access to services of appropriate quality to meet such needs.

### **Article 11 – Professional standards**

1. Professional staff involved in mental health services should have appropriate qualifications and training to enable them to perform their role within the services according to professional obligations and standards.
2. In particular, staff should receive appropriate training on:
  - i. protecting the dignity, human rights and fundamental freedoms of persons with mental disorder;
  - ii. understanding, prevention and control of violence;
  - iii. measures to avoid the use of restraint or seclusion;
  - iv. the limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures.

### **Article 12 – General principles of treatment for mental disorder**

1. Persons with mental disorder should receive treatment and care provided by adequately qualified staff and based on an appropriate individually prescribed treatment plan. Whenever possible the treatment plan should be prepared in consultation with the person concerned and his or her opinion should be taken into account. The plan should be regularly reviewed and, if necessary, revised.
2. Subject to the provisions of chapter III and Articles 28 and 34 below, treatment may only be provided to a person with mental disorder with his or her consent if he or she has the capacity to give such consent, or, when the person does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law.
3. When because of an emergency situation the appropriate consent or authorisation cannot be obtained, any treatment for mental disorder that is medically necessary to avoid serious harm to the health of the individual concerned or to protect the safety of others may be carried out immediately.

### **Article 13 – Confidentiality and record-keeping**

1. All personal data relating to a person with mental disorder should be considered to be confidential. Such data may only be collected, processed and communicated according to the rules relating to professional confidentiality and personal data protection.
2. Clear and comprehensive medical and, where appropriate, administrative records should be maintained for all persons with mental disorder placed or treated for such a disorder. The conditions governing access to that information should be clearly specified by law.

### **Article 14 – Biomedical research**

Biomedical research on a person with mental disorder should respect the provisions of this recommendation and the relevant provisions of the Convention on Human Rights and Biomedicine [, its additional Protocol on Biomedical Research\* ]and the other legal provisions ensuring the protection of persons in research contexts.

### **Article 15 – Dependents of a person with mental disorder**

The needs of family members, in particular children, who are dependent on a person with mental disorder should be given appropriate consideration.

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\* Subject to the adoption of the additional Protocol prior to the adoption of this recommendation

## **Chapter III – Involuntary placement in psychiatric facilities, and involuntary treatment, for mental disorder**

### **Article 16 – Scope of chapter III**

The provisions of this chapter apply to persons with mental disorder:

- i. who have the capacity to consent and are refusing the placement or treatment concerned; or
- ii. who do not have the capacity to consent and are objecting to the placement or treatment concerned.

### **Article 17 – Criteria for involuntary placement**

1. A person may be subject to involuntary placement only if all the following conditions are met:
  - i. the person has a mental disorder;
  - ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;
  - iii. the placement includes a therapeutic purpose;
  - iv. no less restrictive means of providing appropriate care are available;
  - v. the opinion of the person concerned has been taken into consideration.
2. The law may provide that exceptionally a person may be subject to involuntary placement, in accordance with the provisions of this chapter, for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others if:
  - i. his or her behaviour is strongly suggestive of such a disorder;
  - ii. his or her condition appears to represent such a risk;
  - iii. there is no appropriate, less restrictive means of making this determination; and
  - iv. the opinion of the person concerned has been taken into consideration.

### **Article 18 – Criteria for involuntary treatment**

A person may be subject to involuntary treatment only if all the following conditions are met:

- i. the person has a mental disorder;
- ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;
- iii. no less intrusive means of providing appropriate care are available;
- iv. the opinion of the person concerned has been taken into consideration.

### **Article 19 – Principles concerning involuntary treatment**

1. Involuntary treatment should:
  - i. address specific clinical signs and symptoms;
  - ii. be proportionate to the person's state of health;
  - iii. form part of a written treatment plan;
  - iv. be documented;
  - v. where appropriate, aim to enable the use of treatment acceptable to the person as soon as possible.
2. In addition to the requirements of Article 12.1 above, the treatment plan should:
  - i. whenever possible be prepared in consultation with the person concerned and the person's personal advocate or representative, if any;
  - ii. be reviewed at appropriate intervals and, if necessary, revised, whenever possible in consultation with the person concerned and his or her personal advocate or representative, if any.
3. Member states should ensure that involuntary treatment only takes place in an appropriate environment.

## **Article 20 – Procedures for taking decisions on involuntary placement and/or involuntary treatment**

### *Decision*

1. The decision to subject a person to involuntary placement should be taken by a court or another competent body. The court or other competent body should:
  - i. take into account the opinion of the person concerned;
  - ii. act in accordance with procedures provided by law based on the principle that the person concerned should be seen and consulted.
2. The decision to subject a person to involuntary treatment should be taken by a court or another competent body. The court or other competent body should:
  - i. take into account the opinion of the person concerned;
  - ii. act in accordance with procedures provided by law based on the principle that the person concerned should be seen and consulted.

However, the law may provide that when a person is subject to involuntary placement the decision to subject that person to involuntary treatment may be taken by a doctor having the requisite competence and experience, after examination of the person concerned and taking into account his or her opinion.

3. Decisions to subject a person to involuntary placement or to involuntary treatment should be documented and state the maximum period beyond which, according to law, they should be formally reviewed. This is without prejudice to the person's rights to reviews and appeals, in accordance with the provisions of Article 25.

### *Procedures prior to the decision*

4. Involuntary placement, involuntary treatment, or their extension should only take place on the basis of examination by a doctor having the requisite competence and experience, and in accordance with valid and reliable professional standards.
5. That doctor or the competent body should consult those close to the person concerned, unless the person objects, it is impractical to do so, or it is inappropriate for other reasons.
6. Any representative of the person should be informed and consulted.

## **Article 21 – Procedures for taking decisions on involuntary placement and/or involuntary treatment in emergency situations**

1. Procedures for emergency situations should not be used to avoid applying the procedures set out in Article 20.
2. Under emergency procedures:
  - i. involuntary placement or involuntary treatment should only take place for a short period of time on the basis of a medical assessment appropriate to the measure concerned;
  - ii. paragraphs 5 and 6 of Article 20 should be complied with as far as possible;
  - iii. decisions to subject a person to involuntary placement or to involuntary treatment should be documented and state the maximum period beyond which, according to law, they should be formally reviewed. This is without prejudice to the person's rights to reviews and appeals, in accordance with the provisions of Article 25.
3. If the measure is to be continued beyond the emergency situation, a court or another competent body should take decisions on the relevant measure, in accordance with Article 20, as soon as possible.

## **Article 22 – Right to information**

1. Persons subject to involuntary placement or involuntary treatment should be promptly informed,

verbally and in writing, of their rights and of the remedies open to them.

2. They should be informed regularly and appropriately of the reasons for the decision and the criteria for its potential extension or termination.

3. The person's representative, if any, should also be given the information.

### **Article 23 – Right to communication and to visits of persons subject to involuntary placement**

The right of persons with mental disorder subject to involuntary placement:

i. to communicate with their lawyers, representatives or any appropriate authority should not be restricted. Their right to communicate with their personal advocates or other persons should not be unreasonably restricted;

ii. to receive visits should not be unreasonably restricted, taking into account the need to protect vulnerable persons or minors placed in or visiting a psychiatric facility.

### **Article 24 – Termination of involuntary placement and/or involuntary treatment**

1. Involuntary placement or involuntary treatment should be terminated if any of the criteria for the measure are no longer met.

2. The doctor in charge of the person's care should be responsible for assessing whether any of the relevant criteria are no longer met unless a court has reserved the assessment of the risk of serious harm to others to itself or to a specific body.

3. Unless termination of a measure is subject to judicial decision, the doctor, the responsible authority and the competent body should be able to take action on the basis of the above criteria in order to terminate that measure.

4. Member states should aim to minimise, wherever possible, the duration of involuntary placement by the provision of appropriate aftercare services.

### **Article 25 – Reviews and appeals concerning the lawfulness of involuntary placement and/or involuntary treatment**

1. Member states should ensure that persons subject to involuntary placement or involuntary treatment can effectively exercise the right:

i. to appeal against a decision;  
ii. to have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable intervals;  
iii. to be heard in person or through a personal advocate or representative at such reviews or appeals.

2. If the person, or that person's personal advocate or representative, if any, does not request such review, the responsible authority should inform the court and ensure that the continuing lawfulness of the measure is reviewed at reasonable and regular intervals.

3. Member states should consider providing the person with a lawyer for all such proceedings before a court. Where the person cannot act for him or herself, the person should have the right to a lawyer and, according to national law, to free legal aid. The lawyer should have access to all the materials, and have the right to challenge the evidence, before the court.

4. If the person has a representative, the representative should have access to all the materials, and have the right to challenge the evidence, before the court.

5. The person concerned should have access to all the materials before the court subject to the protection of the confidentiality and safety of others according to national law. If the person has no representative, he or she should have access to assistance from a personal advocate in all procedures before a court.

6. The court should deliver its decision promptly. If it identifies any violations of the relevant national legislation it should send these to the relevant body.

7. A procedure to appeal the court's decision should be provided.

## **Chapter IV – Placement of persons not able to consent in the absence of objection**

### **Article 26 – Placement of persons not able to consent in the absence of objection**

Member states should consider applying appropriate provisions to protect a person with mental disorder who does not have the capacity to consent and who is considered in need of placement and does not object to the placement.

## **Chapter V – Specific situations**

### **Article 27 – Seclusion and restraint**

1. Seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed.

2. Such measures should only be used under medical supervision, and should be appropriately documented.

3. In addition, with the exception of restraint used infrequently and for no more than a short period:

- i. the person subject to seclusion or restraint should be regularly monitored;
- ii. the reasons for, and duration of, such measures should be recorded in the person's medical records and in a register.

### **Article 28 – Specific treatments**

1. Treatment for mental disorder that is not aimed at producing irreversible physical effects but may be particularly intrusive should be used only if no less intrusive means of providing appropriate care is available. Member states should ensure that the use of such treatment is:

- i. subject to appropriate ethical scrutiny;
- ii. in accordance with appropriate clinical protocols reflecting international standards and safeguards;
- iii. except in emergency situations as referred to in Article 12, with the person's informed, written consent or, in the case of a person who does not have the capacity to consent, the authorisation of a court or competent body;
- iv. fully documented and recorded in a register.

2. Use of a treatment for mental disorder with the aim of producing irreversible physical effects should be exceptional, and should not be used in the context of involuntary placement. Such a treatment should only be carried out if the person concerned has given free, informed and specific consent in writing. The treatment should be fully documented and recorded in a register, and used only:

- i. in accordance with the law;
- ii. subject to appropriate ethical scrutiny;
- iii. in accordance with the principle of least restriction;
- iv. if an independent second medical opinion agrees that it is appropriate; and
- v. in accordance with appropriate clinical protocols reflecting international standards and safeguards.

### **Article 29 – Minors**

1. The provisions of this recommendation should apply to minors unless a wider measure of protection is provided.

2. In decisions concerning placement and treatment, whether provided involuntarily or not, the opinion of the minor should be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.

3. A minor subject to involuntary placement should have the right to assistance from a representative from the start of the procedure.

4. A minor should not be placed in a facility in which adults are also placed, unless such a placement would benefit the minor.

5. Minors subject to placement should have the right to a free education and to be reintegrated into the general school system as soon as possible. If possible, the minor should be individually evaluated and receive an individualised educational or training programme.

### **Article 30 – Procreation**

The mere fact that a person has a mental disorder should not constitute a justification for permanent infringement of his or her capacity to procreate.

### **Article 31 – Termination of pregnancy**

The mere fact that a person has a mental disorder should not constitute a justification for termination of her pregnancy.

## **Chapter VI – Involvement of the criminal justice system**

### **Article 32 – Involvement of the police**

1. In the fulfilment of their legal duties, the police should coordinate their interventions with those of medical and social services, if possible with the consent of the person concerned, if the behaviour of that person is strongly suggestive of mental disorder and represents a significant risk of harm to him or herself or to others.

2. Where other appropriate possibilities are not available the police may be required, in carrying out their duties, to assist in conveying or returning persons subject to involuntary placement to the relevant facility.

3. Members of the police should respect the dignity and human rights of persons with mental disorder. The importance of this duty should be reinforced during training.

4. Members of the police should receive appropriate training in the assessment and management of situations involving persons with mental disorder, which draws attention to the vulnerability of such persons in situations involving the police.

### **Article 33 – Persons who have been arrested**

If a person whose behaviour is strongly suggestive of mental disorder is arrested:

- i. the person should have the right to assistance from a representative or an appropriate personal advocate during the procedure;
- ii. an appropriate medical examination should be conducted promptly at a suitable location to establish:
  - a. the person's need for medical care, including psychiatric care;
  - b. the person's capacity to respond to interrogation;
  - c. whether the person can be safely detained in non-health care facilities.

### **Article 34 – Involvement of the courts**

1. Under criminal law, courts may impose placement or treatment for mental disorder whether the person concerned consents to the measure or not. Member states should ensure that the person can

effectively exercise the right to have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable intervals. The other provisions of chapter III should be taken into account in such placements or treatments; any non-application of those provisions should be justifiable.

2. Courts should make sentencing decisions concerning placement or treatment for mental disorder on the basis of valid and reliable standards of medical expertise, taking into consideration the need for persons with mental disorder to be treated in a place appropriate to their health needs. This provision is without prejudice to the possibility, according to law, for a court to impose psychiatric assessment and a psychiatric or psychological care programme as an alternative to imprisonment or to the delivery of a final decision.

### **Article 35 – Penal institutions**

1. Persons with mental disorder should not be subject to discrimination in penal institutions. In particular, the principle of equivalence of care with that outside penal institutions should be respected with regard to their health care. They should be transferred between penal institution and hospital if their health needs so require.

2. Appropriate therapeutic options should be available for persons with mental disorder detained in penal institutions.

3. Involuntary treatment for mental disorder should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder.

4. An independent system should monitor the treatment and care of persons with mental disorder in penal institutions.

## **Chapter VII – Quality assurance and monitoring**

### **Article 36 – Monitoring of standards**

1. Member states should ensure that compliance with the standards set by this recommendation and by mental health law is subject to appropriate monitoring. That monitoring should cover:

- i. compliance with legal standards;
- ii. compliance with technical and professional standards.

2. The systems for conducting such monitoring should:

- i. have adequate financial and human resources to perform their functions;
- ii. be organisationally independent from the authorities or bodies monitored;
- iii. involve mental health professionals, lay persons, persons with mental disorder and those close to such persons;
- iv. be coordinated, where appropriate, with other relevant audit and quality assurance systems.

### **Article 37 – Specific requirements for monitoring**

1. Monitoring compliance with standards should include:

- i. conducting visits and inspections of mental health facilities, if necessary without prior notice, to ensure:
  - a. that persons are only subject to involuntary placement in facilities registered by an appropriate authority, and that such facilities are suitable for that function;
  - b. that suitable alternatives to involuntary placement are provided;
- ii. monitoring compliance with professional obligations and standards;
- iii. ensuring powers exist to investigate the death of persons subject to involuntary placement or involuntary treatment, and that any such death is notified to the appropriate authority and is subject to an independent investigation;
- iv. reviewing situations in which communication has been restricted;
- v. ensuring that complaints procedures are provided and complaints responded to appropriately.

2. Appropriate follow-up of the results of monitoring should be ensured.
3. In respect of persons subject to provisions of mental health law, the persons conducting monitoring should be entitled:
  - i. to meet privately with such persons, and with their consent or that of their representatives, have access to their medical file at any time;
  - ii. to receive confidential complaints from such persons;
  - iii. to obtain from authorities or staff responsible for the treatment or care of such persons any information that may reasonably be considered necessary for the performance of their functions, including anonymised information from medical records.

#### **Article 38 – Statistics, advice and reporting**

1. Systematic and reliable anonymised statistical information on the application of mental health law and on complaints should be collected.
2. Those responsible for the care of persons with mental disorder should:
  - i. receive from those responsible for quality assurance and monitoring:
    - a. regular reports, and where possible publish those reports;
    - b. advice on the conditions and facilities appropriate to the care of persons with mental disorder;
  - ii. respond to questions, advice and reports arising from the quality assurance and monitoring systems.
3. Information on the implementation of mental health law and actions concerning compliance with standards should be made available to the public.

**Draft Explanatory Report  
to the draft Recommendation Rec (...)  
of the Committee of Ministers to member states  
concerning the protection of the human rights and dignity  
of persons with mental disorder**

## **Introduction**

1. Mental disorders can have significant effects on a person's emotions, perceptions, and capacities to think and to reason. Such effects may have important consequences for the person's private and family life, as well as consequences in the person's other social roles, for example his or her employment. It is increasingly recognised that mild forms of mental disorder are very common; the World Health Organisation estimates that about 1 in 4 persons will have a mental disorder at some point during his or her life. Often, such disorders do not come to medical attention, or are treated by a primary care physician.
2. Serious mental disorders are far less common. The effects of such disorders are more fundamental, and can involve serious risks to the person's life or health, or to the life or health of others. The potential need to take measures to ensure the protection of such persons, and where necessary society, is recognised in Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950).
3. On 22 February 1983, the Committee of Ministers of the Council of Europe adopted Recommendation R (83)2 to member states *concerning the legal protection of persons suffering from mental disorder placed as involuntary patients*. Since that time, there have been considerable developments in approaches to the care and treatment of those with mental disorder, in particular in relation to the possibility of treating persons with mental disorder outside the hospital setting. The use of certain forms of treatment for mental disorder has also been actively debated.
4. On 12 April 1994, the Parliamentary Assembly of the Council of Europe adopted Recommendation 1235 (1994) *on psychiatry and human rights*, in which it proposed the development of a Recommendation of wider scope that would guarantee respect for the human rights of psychiatric patients.

## **Drafting of the Recommendation**

5. In the light of the Parliamentary Assembly's Recommendation, the Committee of Ministers established a Working Party under the authority of the Steering Committee on Bioethics in order to draw up guidelines to be included in a new legal instrument of the Council of Europe. These guidelines were to be aimed at ensuring the protection of the human rights and dignity of people with mental disorder, especially those placed as involuntary patients, including their right to appropriate treatment.
6. The Working Party was chaired initially by Professor Jan de Boer (Netherlands, 1996-98) and then by Professor David Kingdon (United Kingdom). The members of the Working Party were nominated by relevant Committees of the Council of Europe including the CDCJ (European Committee on Legal Co-operation), the CDSP (European Health Committee), the CDBI (Steering Committee on Bioethics), the CDDH (Steering Committee for Human Rights) and the CDPC (European Committee on Crime Problems). The members were: Mr Frank Schürmann (Vice-Chair, Switzerland), Professor Hans F.M. Crombag (Netherlands, 1996-97), Mr Vincent de Gaetano (Malta, 1996-97), Dr Pierre Lamothe (France, from 1999), Professor Jouko K. Lönnqvist (Finland), Dr Michael Mulcahy (Ireland, from 1998), Mr Ionel Olteanu (Romania, 1997-99), Professor Helmut Remschmidt (Germany, 1998-2001), Professor Dr Peter Riedesser (Germany, from 2001), Professor Emmanuel Roucounas (Greece) and Mrs Mariavaleria Del Tufo (Italy).
7. The Working Party benefited from the valuable experience of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). In particular, it held an exchange of views with its first Vice-President and with an expert to the CPT. Attention is drawn to *The CPT Standards* (CPT/Inf/E (2002)1 rev 2003), and in particular section VI which is devoted to involuntary placement in psychiatric establishments and section IV concerning health care services in prisons. References in this Explanatory Report to the views and expectations of the CPT are based on that document.

8. In January 2000 the Working Party issued, with the authorisation of the Steering Committee on Bioethics, a "White Paper" for the purposes of public consultation with a view to drawing up the proposed guidelines. The White Paper, which was a discussion document, included fifteen elements regarding the protection of persons with mental disorder that could be covered by a future legal instrument. The responses to the consultation supported the need to include all these elements, and also contributed to the further refinement of the principles to be reflected within each element in the future legal text. After the Working Party had agreed on the principles, they were codified into the format of a draft Recommendation of the Committee of Ministers of the Council of Europe. The final text covers all the elements included in the White Paper, expressed in 38 Articles for the sake of clarity.
9. The draft Recommendation was examined by the Steering Committee on Bioethics (CDBI) at its meetings in December 2003 and in March 2004 under the chairmanship of Mrs Dubravka Simonovic (Croatia). The CDBI's work was assisted by a Drafting Group<sup>1</sup>.
10. The Recommendation is accompanied by this Explanatory Report, drawn up under the responsibility of the Secretary General of the Council of Europe. It takes into account the discussions held in the Working Party entrusted with the initial preparation of the Recommendation, in the CDBI and its Drafting Group, and the remarks and proposals made by delegations. The Explanatory Report is not an authoritative interpretation of the Recommendation. Nevertheless, it covers the main issues of the preparatory work and provides information to clarify the object and purpose of the Recommendation and to make the scope of its provisions more comprehensible.

#### **Title**

11. The title identifies this instrument as the "Recommendation Rec (...) of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder". The use of the word "concerning" makes clear that the Recommendation is not a comprehensive account of the human rights of persons with mental disorder; such persons are also entitled to the rights and freedoms set out in other instruments applicable to persons in general, such as the European Convention for the Protection of Human Rights and Fundamental Freedoms ("European Convention on Human Rights") of 4 November 1950 and the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine ("Convention on Human Rights and Biomedicine") of 4 April 1997.

#### **Preamble**

12. The recognition of past and continuing violations of the rights of persons subject to involuntary placement is the reason why the Preamble emphasises that, in particular, those who are subject to involuntary placement or involuntary treatment require appropriate levels of protection.
13. The effects of mental disorder on a person's emotions, thinking and perception may be seen as concerning the essence of a person's individuality. Similarly, treatments that alter such aspects of a person's functioning may also be seen as influencing a person's individuality. Psychiatric treatment and care requires a detailed knowledge of intimate aspects of the person's feelings and beliefs, so that persons with mental disorder may be, or feel that they are, particularly vulnerable in their contact with mental health services. The Preamble emphasises that such vulnerability must never be exploited, in particular emotionally (or psychologically), physically, sexually or financially.
14. The potential vulnerability of persons with mental disorder means that an appropriate regulatory framework to guide mental health professionals in their practice is required. The law, independent monitoring bodies and the framework of professional standards will set the context within which mental health professionals work. However, they remain responsible for upholding, as far as they are able to do so, the relevant ethical and legal standards in their individual contacts with persons with mental disorder.
15. The Preamble requires mental health professionals to regularly review their practice. This is discussed in paragraphs 80-84 below. Further, by encouraging openness and transparency, the requirement aims to minimise the risk of exploitation of persons with mental disorder.

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## Chapter I – Object and scope

### Article 1 – Object

16. The aim of the Recommendation is to protect the dignity, human rights and fundamental freedoms of all persons with mental disorder. Those who are subject to involuntary placement or to involuntary treatment may be regarded as a group of such persons who are particularly vulnerable and hence their need for protection is emphasised.
17. The second paragraph of this Article makes clear that States may apply rules of a more protective nature than those contained in the Recommendation. In other words, the text lays down common standards with which States should comply, while allowing them to provide greater protection of persons with mental disorder.

### Article 2 – Scope and definitions

18. The first paragraph of the Article specifies that the Recommendation applies to persons with mental disorder defined in accordance with internationally accepted medical standards. However, the provisions of the Recommendation only apply to a person with mental disorder insofar as they are relevant to that person's condition.
19. Relevant provisions of the Recommendation are also applicable to a person who is subject to involuntary placement according to Article 17 in order to determine whether a mental disorder is present.
20. An example of an internationally accepted medical standard is that provided by Chapter V of the World Health Organisation's *International Statistical Classification of Diseases and Related Health Problems*, which concerns *Mental and Behavioural Disorders* (ICD-10). This includes mental disorders that occur predominately in childhood or in old age (such as dementia) as well as disorders occurring in adult life, including mental disorders due to the use of alcohol and other psychoactive substances. This method of defining mental disorder aims to prevent idiosyncratic approaches to diagnosis. So-called "sluggish schizophrenia" is one example of such an idiosyncratic approach; it was a diagnosis applied under certain totalitarian regimes in the past but not recognised elsewhere in the world.
21. The ICD-10 does not use the term "mental illness" although it describes disorders such as schizophrenia and bipolar affective disorder that are commonly regarded as illnesses. ICD-10 also includes disorders of personality, and describes such disorders in adults as follows:

"These are severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood."
22. The ICD-10 also uses the term "mental retardation" to describe the following condition:

"A condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence i.e. cognitive, language, motor and social abilities."
23. Outside the classification the term "mental retardation" is seldom used, alternatives such as "learning disability" or "mental handicap" being preferred in different countries. The preferences of persons with such conditions concerning the description of their condition should also be taken into account. No terminology will be considered ideal by everyone. In this Report, the term "mental handicap" is used.
24. Persons with mental handicap and persons with mental illness are very different groups of people and their needs should not be equated. However, both groups of people may be vulnerable and ensuring their appropriate protection is central to this Recommendation. The Recommendation contains provisions that may be relevant to both groups of people, but they are only applicable to a particular person insofar as relevant to that person's condition.
25. In particular, the general provisions of Chapter II may be relevant to persons with mental handicap, notably the principle of least restriction (Article 8) and the requirements of Article 9.1 concerning

environment and living conditions, as well as the protective provisions of Article 30 concerning procreation. Persons with a mental handicap sometimes exhibit seriously aggressive and/or irresponsible behaviour. Such behaviour may or may not be associated with mental illness. In the absence of less restrictive or specific alternatives the use of mental health legislation may be considered, in which case Chapter III of the Recommendation would be relevant. However, involuntary measures should never be applied to a person with mental handicap merely on the basis of that condition. The relevant criteria and procedures set out in Chapter III should be fulfilled before any person with a mental disorder, whether mental illness, mental handicap or any other mental disorder, may be subject to an involuntary measure.

26. The second paragraph of Article 2 repeats a principle set out in Article 2 of Recommendation R (83)2 of the Committee of Ministers to member states *concerning the legal protection of persons suffering from mental disorder placed as involuntary patients*. This principle follows the jurisprudence of the European Court of Human Rights, for example in its judgement in the *Winterwerp* case, that: "... Article 5.1e [of the European Convention on Human Rights] obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society."<sup>2</sup>
27. Paragraph 3 defines certain key terms used in this Recommendation.
28. The characteristics of a court, court-like body or tribunal should be interpreted in line with the case law of the European Court of Human Rights. Article 6 of the European Convention on Human Rights refers to "an independent and impartial tribunal established by law". According to the European Court of Human Rights, the "tribunal" is characterised by the fact that it is a body with a judicial function, namely determining matters within its competence on the basis of rules of law and after proceedings conducted in a prescribed manner. The tribunal should satisfy the following conditions:
  - i. is established by law and meets the requirements of independence and impartiality;
  - ii. can determine all aspects of the dispute or charge to which Article 6 applies and hence give a binding decision on the matter before it;
  - iii. is accessible to the individual concerned.
29. In this Recommendation "facility" refers to premises (encompassing facilities and units) in which a person with mental disorder may be placed. The term should be understood in a broad sense. In Chapter III, the more specific term "psychiatric facilities" is used (see paragraph 117 below).
30. Different states may have different names for the role of a "personal advocate" as defined in this Recommendation. According to the national system concerned, personal advocates may be nominated by the person or provided by law. The personal advocate might for instance be a family member, a lawyer or a counsellor appointed by an authority.
31. A representative is a person provided for by law (for example a parent in relation to a child) or appointed through a legal process, for example by a court.
32. When a person comes into contact with mental health services for the first time, it is not always possible to make an exact diagnosis immediately. If appropriate, a provisional diagnosis is made which can then be reviewed in the light of further observation, including where relevant the person's response to treatment offered on the basis of the provisional diagnosis. Therefore, the term "diagnosis" is included within the definition of "therapeutic purposes".
33. With regard to the definitions of "treatment" and "therapeutic purposes", it should be noted that some mental disorders, such as dementia, are not curable at the present time. However, in some cases it may be possible to slow down the rate of deterioration. Other disorders, such as bipolar affective disorder, may be recurrent. Although it may not be possible to cure the disorder, an acute episode of mania or depression can be treated and the person returned to a normal level of functioning. Both of these examples would be covered by the reference to "control" in the definition of therapeutic purposes used in this Recommendation. Similarly, interventions that aim to limit the impact of deficits in functioning as a result of schizophrenia on a person's life (normally referred to as rehabilitation) would also be covered by the same reference.
34. In the definition of treatment, the reference to physical interventions includes the use of pharmacological interventions.
35. The reference to the social dimension of a person's life in the definition of treatment reflects the fact that the existence of positive social relationships with others, for example family and friends, in which

<sup>2</sup>*Winterwerp v The Netherlands, judgment of 24 October 1979, Application number 00006301/73*

a person feels valued and is able to express him or herself to the extent he or she wishes to do so, can have a beneficial effect on mental health. Persons with mental disorder, particularly those with mental disorders of a serious nature, who are living in a situation of relative isolation may benefit from interventions designed to improve the social dimension of their life, for example attendance at a specialist day centre, social activity centre, or in a group activity.

36. The meaning of the following terms for the purposes of this Recommendation was also agreed:  
“Psychiatrist” means a medical doctor with special expertise and qualifications in assessment, diagnosis and treatment of mental disorder.  
“Doctor having the requisite competence and experience” means a medical doctor who is not necessarily a psychiatrist, as may be the case in emergency situations, but who has sufficient experience to deal with the medical and administrative issues raised by placement or treatment whether on a voluntary or involuntary basis.  
“Risk” can be interpreted as the chance that harm may occur.
37. “Placement” refers to the action of being placed in a particular facility for a particular purpose or purposes; in the context of this Recommendation those purposes would be one or more therapeutic purposes. Such placements can be on a voluntary basis, for example when a person is offered a place in a hospital or a rehabilitation hostel and accepts that offer. Alternatively, placements can be on an involuntary basis under the conditions set by Chapter III of this Recommendation.
38. The concept of “emergency situations” is explained in paragraphs 98 and 160 of this Report.

## **Chapter II – General provisions**

### **Article 3 – Non-discrimination**

39. The requirement in paragraph 2 to take measures to eliminate any form of discrimination on the grounds of past or present mental disorder is the corollary of the general principle prohibiting discrimination on any grounds set out in Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms of 4 November 2000 (ETS 177). This general principle, set out in paragraph 1, is also acknowledged at a global level, for example in Principle 1(4) of the United Nations Resolution A/RES/46/119 of 17 December 1991 concerning *The protection of persons with mental illness and the improvement of mental health care*. Paragraph 2 reflects the fact that examples of discrimination against persons on the grounds of mental disorder still exist at present.
40. In this Article, as in Protocol No. 12, the other instruments of the Council of Europe, and the case law of the European Court of Human Rights, the term “discrimination” is understood to mean “unfair discrimination”. In particular, the principle cannot prohibit positive measures that may be implemented with the aim of re-establishing a balance in favour of those at a disadvantage on the grounds of their past or present mental disorder. Hence, special measures undertaken to protect the rights or secure the advancement of persons with mental disorder should not be regarded as discriminatory.
41. The possibility that particular groups of people with past or present mental disorder may be subject to discrimination should be recognised and may need to be addressed. For example, some people have reported particularly negative responses if they inform others that they have been admitted to a psychiatric facility or have been subject to an involuntary measure. However, a proportionate measure which is taken to prevent potentially serious risk to others – for example refusing to grant a person with a history of recurrent severe mental illness a firearms licence – should not be regarded as discrimination within the meaning of this Article or the other instruments of the Council of Europe.
42. Persons who have, or have had, mental disorders linked to the use of alcohol or psychoactive substances are often negatively perceived by the public, as may those who may be classified by the ICD-10 as having a disorder of sexual preference such as paedophilia. In the example of paedophilia, the protection of children is the paramount consideration. However, it is important to ensure that where a distinction is made (for example with regard to civil rights or access to services) between persons classified as having paedophilia and other persons that the distinction is justifiable. The existence of negative attitudes to specific groups of people may indicate the need for particular attention in addressing discrimination directed at such groups, without prejudice to the applicable sanctions in the case of criminal offences.

43. Discrimination may also arise within health services themselves, for example by patients with mental disorder being given lower priority for treatment of their physical illnesses. Those close to persons with mental handicap have expressed concerns of this nature. On a wider scale, whether the allocation of personnel and financial resources to mental health services is fair in comparison to the allocation made to physical health services warrants consideration.
44. Persons with mental disorder may meet prejudice and discrimination in their daily life, for example in relation to employment or insurance. Accommodation may also be problematic; for example, there have been reports of local residents opposing new housing schemes in their neighbourhood for people who have mental disorder.
45. Discrimination is separate from stigma, although stigmatisation may increase the likelihood of discrimination. Society's perception of mental disorder influences the likelihood of either stigmatisation or discrimination. The media's role in addressing discrimination should be considered; for example, media use of derogatory terms for persons with mental disorder, or incorrect use of the term "schizophrenia" in inappropriate situations may reinforce negative attitudes to persons with mental disorder.

#### **Article 4 – Civil and political rights**

46. This Article draws attention to the need to take due account of the provisions of Articles 3 (which concerns the prohibition of torture and inhuman or degrading treatment or punishment), 8 (respect for private and family life), 10 (freedom of expression) and 12 (right to marry and found a family) of the European Convention on Human Rights, as developed and interpreted by the case-law of the European Court of Human Rights. Consideration should also be given to the *International Covenant on Civil and Political Rights* (United Nations, 1966).
47. Restrictions on these rights should be an exception rather than the norm. Given the importance of these rights, any restrictions on them must be prescribed by law. Such rights may be restricted for various reasons, for example under criminal law or laws relating to child protection, but the second paragraph emphasises that restrictions should be in conformity with the provisions of the European Convention for the Protection of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder. Any such restriction should therefore respect the guarantees provided by that Convention (for example that the restriction is proportionate to the aim pursued) and the relevant jurisprudence of the European Court of Human Rights concerning these guarantees.
48. The rights to live and to work in the community, which are specified in Principle 3 of the United Nations Resolution A/RES/46/119 concerning *The protection of persons with mental illness and the improvement of mental health care* are specific examples of civil and political rights. Any restriction on those rights should therefore comply with the conditions set out in paragraph 2 of this Article.
49. Principle 3 of Council of Europe Recommendation R (99)4 *on principles concerning the legal protection of incapable adults* states that the person concerned "should not automatically [be deprived] of the right to vote, or to make a will" and that he or she "whenever possible ... should be enabled to enter into legally effective transactions of an everyday nature". As noted in the context of economic interests in paragraph 57 below, suitable measures should be available to manage the affairs of a person lacking capacity for the benefit of the person concerned and to secure his or her welfare.

#### **Article 5 – Promotion of mental health**

50. Public education about mental disorder is important in addressing discrimination and stigma, but also has wider purposes. Fears based on lack of information about the nature of mental disorder and the possibilities for treatment contribute to negative attitudes (of family members and friends as well as of the wider public) to those who have a mental disorder. These negative attitudes can contribute to a person's failure to seek help and appropriate treatment, and may impair the effectiveness of treatment. Article 5 therefore emphasises the importance of promotion of mental health. As well as helping to combat discrimination such activities, which may be included in health education programmes, should enable members of the public to become better informed about:
  - action they could take to prevent the development of mental disorder;
  - how to recognise the development of such disorders in themselves and those close to them; and

- the options that may be available to treat such disorders. Increasing public awareness in this way may encourage people to seek medical treatment more quickly if they develop a mental disorder.

## **Article 6 – Information and assistance on patients’ rights**

- When a person is either placed or treated for mental disorder, whether on a voluntary or involuntary basis, he or she may be referred to as a “patient” and should be informed of his or her rights. In the context of mental health services in different countries, different terminology may be used. Some examples include “clients”, “users” or “consumers”. However, all such persons are entitled, if they are placed or treated for mental disorder, to the same rights to information and assistance. Article 22 of this Recommendation covers the situation in which a person is subject to involuntary measures, when specific information will also be required regarding the measure concerned.
- All patients need general information on their rights. These include the right, when the person has the capacity to consent, to withhold consent to treatment (unless subject to involuntary treatment). People should also have the right to a “personal advocate”, who can help to promote their interests and provide them with moral support in situations in which they feel vulnerable, such as interviews with senior mental health professionals. The personal advocate could be someone close to the person concerned, such as a family member or friend, or a person provided by an advocacy service or voluntary body who has been trained to take up this role, or a counsellor appointed by an authority. The possibility of a lawyer acting in this non-legal role is not excluded. An individual may choose not to have a personal advocate, but should be aware that they can have access to a competent person or body independent of the mental health service that can, if necessary, assist them in the exercise of their rights. Finally, the patient should be aware of the procedure for making a complaint.
- Article 22 requires that patients subject to involuntary measures receive information about their rights in written form. Although Article 6 does not specify that the information to be given to all patients should be given in writing to do so would be good practice. However, written information should not be regarded as a substitute for information given face-to-face, but as a supplement to such information.
- When the person is not able to understand the information and has a representative, that representative should be given the information. In this situation, it is also good practice to give the information to the person’s personal advocate, if any. Again, it would be good practice to provide the information in writing.

## **Article 7 – Protection of vulnerable persons with mental disorders**

- People may be regarded as being vulnerable due to cognitive, situational, institutional, deferential, medical, economic, and social factors or to a combination of those factors:
  - Persons with cognitive vulnerability may lack capacity to make an informed decision on whether or not to give consent to a proposed placement or treatment. Such persons might be minors, or persons with dementia or mental handicap. The Preamble emphasises that persons with mental disorder should never be exploited. Reports of sexual exploitation of persons with mental handicap highlight the need to be aware of the vulnerability of such persons, particularly in institutional settings. Article 7 highlights the need to have measures in place to prevent such exploitation.
  - Persons with situational vulnerability may normally have capacity to make a decision, but are deprived of their ability to exercise their capacity by the relevant situation (for example during an emergency or due to lack of fluency in the language being used to give information and request consent).
  - Persons subject to institutional vulnerability could be individuals with full cognitive capacity to consent, but who find themselves subject to the authority of persons or bodies who could have their own, and possibly conflicting, interests. This type of vulnerability may be particularly applicable to those with the early stages of dementia, mental handicap or long-term psychotic disorders, especially those treated in nursing homes or similar places who are unable to consent or resist possible infringements of their human rights. Persons subject to institutional vulnerability could also be described as being dependent.
  - Deferential vulnerability is similar to institutional vulnerability, but in contrast to institutional vulnerability, it is characterised by informal, rather than formal, hierarchies. These hierarchies can be

based on social frameworks or on subjective deference to the opinion of a family member. A person being cared for by family members at home may also be described as being dependent. Patients may also feel deferential to the wishes (perceived or real) of his/her mental health professional.

- Differential vulnerability may also be relevant when a person belongs to a close-knit group, in which there is a more or less formalised hierarchy, which shares common beliefs and aims. If the person has few social links outside the group the person may feel pressure, whether real or imagined, to conform to the views of the hierarchy.
- Medical vulnerability particularly affects those with disorders for which there are no totally satisfactory standard treatments. This may be relevant to some patients with schizophrenia, or patients with dementia. Such persons – or their family members - may be vulnerable to exploitation by someone promising a “miracle cure”. However, the impact of any mental illness may threaten a person’s self-image and sense of identity. If the person has insight into their situation, the person’s desire to return to his or her “normal self” may render the person vulnerable and unduly susceptible to, for example, advice from others, advertising, or claims concerning potential (in some cases expensive) treatments.
- Economic vulnerability affects those with capacity to consent but who may, for example, be induced to take part in a research project to obtain a financial gain or in order not to lose access to some benefits, even if they would not otherwise participate in the research.
- Social vulnerability arises from the position of certain groups in a given society. Such groups may be stereotyped, may have been historically discriminated against, may have recently arrived in the community, may not speak the language, and may be economically disadvantaged (like the economically vulnerable). One type of example might be, in certain circumstances, ethnic minority groups or foreigners; another type of example might be persons convicted of sexual offences. As stated in ICD-10, homosexuality is not a mental disorder. Nevertheless in some societies those of homosexual orientation may face discrimination, which may increase the risk of the development of a mental disorder such as depression. As noted in paragraph 35, some people with serious mental disorder live in relative social isolation; such isolation can also be a source of social vulnerability.

56. Thus persons with mental disorder may be vulnerable even if they have capacity to consent. However, those who do not have such capacity may be particularly vulnerable. The second paragraph of this Article highlights the need for measures to protect the economic interests of vulnerable persons – for example, when another person administers the person’s finances on his or her behalf. The provisions of Council of Europe Recommendation R (99)4 *on principles concerning the legal protection of incapable adults* should be considered where relevant. Any arrangements should be carefully regulated and subject to review by monitoring bodies to ensure that, as required by Principle 8 of Recommendation R (99)4, the interests and welfare of the person concerned remain the paramount consideration. Such arrangements should be discontinued if the person regains capacity to manage his or her affairs.

57. Protection of economic interests is not only relevant to persons, such as those with dementia, who may need their finances administered over a long period. An acute episode of a mental disorder such as the manic phase of bipolar affective disorder may result in the person spending money that he or she does not have, or making unwise decisions in relation to his or her employment and hence endangering his or her future economic situation. Hence, measures should be available to protect the economic situation of people with mental disorder, for example through guardianship or other appropriate means. As emphasised by Principle 16 of Recommendation R (99)4 *on principles concerning the legal protection of incapable adults*, there should be adequate control of the operation of protective measures and of the acts and decisions of representatives. Such control by an independent source can prevent misuse of the person’s resources. Further, measures to protect persons with mental disorder in relation to their employment may be necessary.

#### **Article 8 – Principle of least restriction**

58. This is a fundamental principle, and again one that is recognised internationally by Principle 9(1) of the United Nations Resolution A/RES/46/119 concerning *The protection of persons with mental illness and the improvement of mental health care*. The environment in which it is appropriate for a person to be treated may vary throughout their illness; for example a person with severe mania who is subject to involuntary placement and involuntary treatment may need to be initially treated in an environment which includes certain restrictions (such as a lock on the door of the ward). As the person’s illness improves, the principle of least restriction implies that they should be moved to a

less restrictive environment when this would be appropriate to the person's health needs. The application of the principle when a person with mental disorder has committed a serious criminal offence is discussed further in paragraph 76. The principle is further developed in specific contexts in the Recommendation, for example in the need to make alternatives to involuntary measures as widely available as possible, and in the use of seclusion or restraint (Article 27) or the specific treatments covered by Article 28.

59. The reference to "intrusive treatment" should not be equated with "invasive treatment". Individuals may vary in their perception of the intrusiveness of a treatment. For example, some people may consider a type of psychotherapy in which it is necessary to explore intimate beliefs and feelings as more intrusive than the use of medication. Other people may take the opposite view. That is why the Recommendation emphasises in Article 12 that the person's opinion should be taken into account in developing his or her treatment plan.
60. Furthermore, in some circumstances a person may wish to waive his or her right to the least intrusive treatment available. He or she might view psychotherapy as the least intrusive treatment, but recognise that medication may result in a more rapid improvement in his or her condition, and therefore prefer to take medication.
61. The references to availability in this Article should be understood to refer to what is available in the country or region concerned. "Region" may signify several countries in geographical proximity.
62. The reference to protection of the safety of others should be understood in a broad sense. For example, a person may feel as threatened by persistent psychological harassment or "stalking" as by a physical assault.

#### **Article 9 – Environment and living conditions**

63. The first paragraph of this Article reflects Principle 13(2)(d) of the United Nations Resolution A/RES/46/119 concerning *The protection of persons with mental illness and the improvement of mental health care*. Examples of vocational rehabilitation measures include vocational guidance, vocational training and placement and support services that can help persons with mental disorder to secure or retain employment in the community. In some cases, persons have been institutionalised for many years from an early age and hence may have never been integrated into the community during, in particular, their adult life. A wide range of rehabilitation measures may be necessary in order for such persons to be integrated into the community when appropriate.
64. Persons with mental disorder may be placed in a range of different facilities. These may include purpose built psychiatric hospitals, psychiatric wards in general hospitals, and a range of different accommodation in the community (such as a rehabilitation hostel or a sheltered housing scheme). Patients may be briefly placed in facilities designed for the treatment of persons with physical health needs (for example, in a general hospital). However, the Article only refers to facilities designed for the placement of persons with mental disorder. Persons with mental handicap may also be placed in a range of different facilities; such facilities should take account of their needs, in particular for a positive therapeutic environment and of their rights, including the right to privacy.
65. The vulnerability of persons who are placed, particularly those subject to involuntary placement, should never be forgotten. Even today, there are reports of psychiatric facilities in Europe in which the fundamental means necessary to support life (food, warmth, and shelter) have not been supplied, as a result of which patients are reported to have died from malnutrition and hypothermia. Such conditions are totally unacceptable. The fundamental means to support life are necessary in any therapeutic environment.
66. Particular attention should be paid to paragraphs 34 to 36 of the 8th general report on the activities of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (document CPT/Inf (98)12) which drew attention to a number of factors which can create a positive therapeutic environment for persons placed as involuntary patients in a psychiatric establishment. These include:
  - sufficient living space per patient as well as adequate lighting, heating and ventilation;
  - decoration of both patients' rooms and recreation areas;
  - the provision of bedside tables and wardrobes and individualisation of clothing;
  - allowing patients to keep certain personal belongings;

- the preservation of a degree of privacy, in particular, large-capacity dormitories depriving patients of all privacy should be avoided;
- patients who so wish should be allowed to have access to their room during the day rather than being obliged to remain assembled together with other patients in communal areas;
- adequate food from the standpoint of quantity and quality, provided under satisfactory conditions; catering arrangements should also take into account patients' customs and beliefs and the needs of those with disabilities. As noted in paragraph 65 above, the problem of malnutrition must be avoided. However, in some societies obesity (with its resultant health effects) is an increasing problem and it is good practice to provide food choices for patients that enable them to satisfy their appetite whilst maintaining a healthy weight.

67. Although these principles were developed in the context of involuntary placement, they are also relevant to facilities in which patients are subject to voluntary placement.

68. The requirement of the second paragraph of this Article for registration of facilities designed for the involuntary placement of persons with mental disorder aims to facilitate the appropriate inspection and review of such premises, which is addressed in Article 37.1 of the Recommendation. The Recommendation, this Explanatory Report and guidance from other bodies (for example the CPT and professional bodies) may assist in developing criteria for deciding whether registration of a facility is appropriate – for example, could the standards of care foreseen in the Recommendation be delivered in a particular facility? However, it is for member states to determine appropriate mechanisms for registration of a facility.

#### **Article 10 – Health service provision**

69. The first indent of this Article builds on the principle set out in Article 3 of the Convention on Human Rights and Biomedicine, which specifies that “Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.”

70. The requirement of equitable access also applies to the provision of medicines and other forms of treatment. As discussed in paragraph 148, any treatment should be delivered in accordance with professional obligations and standards. Hence, there should be appropriate provision of services to monitor the effects of treatment. This is particularly important in the case of certain medicines used to treat some forms of mental disorder. Lithium carbonate, which may be used to control bipolar affective disorder, is one example. This medication can be very effective, but regular blood tests are required to ensure that the dose used remains both therapeutic and safe for the patient.

71. The reference in indent one to different groups of people with mental disorder highlights the importance of diversity of provision. Article 29.4 of the Recommendation sets out the general principle that children with mental disorder should not be placed in facilities in which adults are also placed, unless such a placement would benefit the child. Older patients may be physically frail, and hence placement in a facility that also accepts younger acutely psychotic patients may present risks to them rather than the protection to which they are entitled. Furthermore, the demands of caring for acutely ill people may mean that if patients in need of rehabilitation are placed in the same part of a facility then the needs of the latter group may receive insufficient attention. Similarly, acute illnesses vary in severity and it may be beneficial to patients if they can, where possible, be placed in different parts of a facility depending on the severity of their condition.

72. Persons with mental handicap also have differing needs and require a range of facilities appropriate to those needs, including day hospitals and different types of hospital facilities. Children and adolescents with mental handicap have particular needs in relation to education and rehabilitation and appropriate provision should be made to meet those needs. It cannot be assumed that mental health professionals whose training has enabled them to become highly competent in the treatment of other forms of mental disorder will be equally competent, without further training, in meeting the needs of persons with mental handicap, particularly when the handicap is severe. Placement facilities should be available locally and be of a reasonable standard.

73. Early intervention in order to maintain or improve the state of health of persons with mental disorder and prevent deterioration in their condition requires a range of accommodation, employment and therapeutic options to be readily available, taking into account cultural considerations and the needs of individuals with sensory impairments. Many mental disorders, such as schizophrenia and bipolar affective disorder, can be recurrent. If a person has been subject to involuntary measures in the

past, the availability of after-care and early intervention services can help to minimise the need for placement in the future.

74. In addition to the need for facilities suitable to the different needs of different groups of acutely ill people, the need for a range of facilities suitable for those who have more chronic illnesses or who need rehabilitation should be taken into account. In this context, the health needs of persons with mental disorders linked to the use of alcohol or other psychoactive substances should not be forgotten.
75. Involuntary placement and involuntary treatment are measures that involve a significant restriction of the rights of the individual concerned. They should be a last resort. Indent ii. of Article 10 emphasises the need to develop alternatives to involuntary placement and involuntary treatment, in accordance with the principle of least restriction. The psychiatric literature both in Europe and in the United States of America has demonstrated that the need for placement of acutely ill patients can be reduced by the use of day hospitals or home treatment teams. Such alternative facilities need to be appropriately resourced if they are to provide a safe, and sustainable, alternative for patients. Other forms of support, including social welfare assistance and the use of effective psychosocial interventions may help to minimise the need for placement.
76. A very small minority of persons with mental disorder commit serious criminal offences. For the protection of the community, facilities need to be available to meet the health needs of such persons whilst providing an appropriate degree of security to protect society. However, the principle of least restriction set out in Article 8 is also relevant to this group of people with mental disorder. Therefore, a range of facilities providing high, medium, and low levels of security are necessary in order that such persons can be placed in facilities which are appropriate to their health needs and the need to protect the safety of others according to their progress during their treatment. In some cases, a person who is not involved with the criminal justice system may be assessed as representing a significant risk of serious harm to others. In accordance with indent i. of this Article, facilities with appropriate levels of security to meet the needs of this group should also be available.
77. People can develop mental disorder whilst in prison. Although it may be possible and appropriate to treat some of those people in prison, others may require transfer to a health service facility to have their health needs met. Appropriate provision is therefore needed for such patients. The treatment of mentally disordered persons in penal institutions is considered in Article 35 of the Recommendation.
78. The fourth indent of Article 10 emphasises the physical health care needs of persons with mental disorder. Physical health needs include needs for dental care. Persons with mental disorder, particularly those with mental disorders of a serious nature, have increased morbidity and mortality rates due to physical illness. Therefore their physical health requires special attention, including the use of appropriate health screening. A person subject to placement, whether voluntarily or involuntarily, should always be offered an appropriate physical examination.
79. This Recommendation only addresses treatment for mental disorder. However, national law should provide an appropriate mechanism for authorising treatment for a physical disorder unrelated to a person's mental disorder if the person does not have the capacity to consent. Article 6 of the Convention on Human Rights and Biomedicine addresses such situations.

## **Article 11 – Professional standards**

80. Article 4 of the Convention on Human Rights and Biomedicine requires that any intervention in the health field be carried out in accordance with relevant professional obligations and standards. This principle is applicable to interventions on persons with mental disorder. Professional staff should avoid the situation in which they may have conflicting roles and duties towards a person with mental disorder. For example, it would be problematic for a member of the clinical team responsible for the treatment of the individual concerned to also act as the patient's personal advocate.
81. Article 11 of this Recommendation emphasises the need for professional staff to have appropriate qualifications and training to enable them to fulfil their role. It is good practice for professional staff to be registered with a professional body that can attest their qualifications. The reference to "training" refers to training both before and after receiving a final professional qualification. The need for professional staff to have training or other opportunities to keep up to date with developments in professional practice (sometimes referred to as continuing professional development) in order to maintain their professional standards should be recognised. As emphasised in the Preamble, professional staff should regularly review their practice. Such review may include both regular

updating of knowledge, taking into account international developments, and review and audit of the professional's clinical practice in order to ensure high quality care.

- 82. Such professional training should also take into account international developments, in particular developments that may permit less restrictive interventions, and widespread changes in attitudes to certain forms of intervention. The use of cage beds (a bed with a cage placed on top of it made of either metal bars, or metal bars and netting, to enclose a person within the confines of the bed) is one example. Concerns have been expressed about the human rights implications of the use of such beds. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has called, after observing such beds on certain of its visits, for them to be withdrawn. In many countries such beds are never used, and this has been the case for many years. In other countries where such beds were used, the level of use has declined as the justification for them has been increasingly questioned and alternative methods of achieving the same purpose in a less restrictive manner have been introduced.
- 83. Continuing professional development is also important in order to ensure that professionals know about new developments, for example, new less intrusive forms of treatment that are as, or more, effective than the treatment currently used. However, the potential impact of a new treatment on a patient's quality of life (for example, as a result of side-effects of medication) also needs to be considered in deciding whether or not such a treatment is appropriate in a particular situation. Professionals should also be aware of the pharmacoeconomic dimensions of treatment.
- 84. The CPT has also highlighted the risk of staff in psychiatric facilities becoming isolated, and considers it highly desirable that staff are offered training opportunities outside their own facility, as well as secondment opportunities.
- 85. Both initial qualifications and further training should address the ethical implications of the person's role and the ethical dilemmas that may arise in mental health care. The World Psychiatric Association has set out the *Madrid Declaration on Ethical Standards for Psychiatric Practice* (1996; amended 2002). In particular that Declaration includes a section on the violation of clinical boundaries and trust between psychiatrists and patients. It emphasises, as does the Preamble to this Recommendation, the professional responsibility to avoid exploitation of the patient, particularly in relation to any form of sexual behaviour. A positive therapeutic relationship between staff and the persons for whom they care is of central importance in mental health care. Staff therefore need to be aware of the implications of their attitudes and approach to such persons on the development of the therapeutic relationship. Protecting the dignity, human rights and fundamental freedoms of persons with mental disorder is a fundamental professional obligation. Paragraph 2 emphasises the need for this obligation to be reinforced by training. However, staff should be aware of the need to respect this obligation from the start of their work.
- 86. The second paragraph highlights training regarding the protection of dignity and human rights, which is important for all staff that have contact with persons with mental disorder. Training in relation to violent, or potentially violent, situations is also highlighted; staff should receive such training if appropriate to their work. The central principle is that staff should aim to avoid situations escalating into violence, both by understanding factors that may lead to such escalation (so that staff can as far as possible minimise such factors) and by the use of techniques (such as verbal de-escalation) that can reduce the risk of violence and in particular reduce the need to use either restraint or seclusion. Article 27 of this Recommendation covers restraint and seclusion.
- 87. Inappropriate application of methods of restraint can be dangerous for both the patient and the health care professionals concerned. All staff that may need to use such methods should have prior training in their correct application. Such training should also cover the benefits and risks of different methods of restraint and of seclusion, and the limited circumstances in which each measure may be justified.
- 88. The second paragraph does not aim to be a comprehensive account of the training requirements of staff working in mental health services. In the preparation of the Recommendation, it was noted that certain important areas of training, for example in psychosocial aspects of treatment and rehabilitation and in providing information and counselling to family members who act as carers to a person with mental disorder, often receive insufficient attention.

## Article 12 – General principles of treatment for mental disorder

89. This Article sets out the general principles of treatment that are applicable to all patients with mental disorder. The term “treatment”, which is defined in Article 2, has a broad scope. Article 19 sets out additional principles applicable to involuntary treatment. Article 28 sets out additional requirements for the use of particular forms of treatment. Article 28.2, covering treatments for mental disorder that are intended to be irreversible, requires consent to be given by the person him or herself. Such treatments cannot be given with the authorisation of a representative. Article 34 covers treatments that may be imposed by the courts in the context of the criminal justice system.

90. Paragraph one emphasises the importance of an appropriate individualised treatment plan. When a person has a mild mental disorder that is treated by a primary care physician, that plan may be simple and prepared in discussion between the doctor and the patient. In an emergency situation, the initial plan may be directed at resolving that situation, after which the plan will be further developed.

91. When a person is placed in a facility for treatment of his or her mental disorder the treatment plan will be more complex. The treatment plan may also address behaviour arising as a consequence of the patient's mental disorder. Additional requirements for involuntary treatment plans are provided in Article 19.2. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has highlighted, in the context of involuntary placement, elements that they consider a treatment plan should contain. Such elements are also relevant to voluntary placements; therefore a treatment plan should contain a wide range of therapeutic and rehabilitative activities, including where appropriate:

- Pharmacotherapy;
- Occupational therapy;
- Group therapy;
- Individual psychotherapy;
- Rehabilitative activities relevant to daily living, for example concerning personal hygiene, shopping, cooking and use of public services;
- Art and drama;
- Music and sports.

92. Furthermore, the CPT has highlighted the importance of recreational activities for patients and hence it is desirable for patients to have access to suitably equipped recreation rooms and opportunities to take outdoor exercise.

93. Wherever possible, the treatment plan should be prepared in consultation with the person concerned. The aim is to enable the person to make informed decisions about his or her treatment plan in partnership with the clinical team. It may also be helpful to involve those close to the person in the preparation of the plan. If the person has the capacity to consent, and refuses consent to the clinical team contacting those close to him or her, this refusal should be respected. However, if those close to the person contact the clinical team and offer information relevant to the person's condition this information can be accepted. Even if the person is too ill to be fully involved in the development of the plan, paragraph one makes clear that attempts should be made to establish his or her opinion and to take this into account.

94. Articles 5 and 6 of the Convention on Human Rights and Biomedicine set out general principles of consent to an intervention, where a person has the capacity to give consent; and authorisation of the intervention when a person does not, according to law, have the capacity to give consent him or herself. These principles are reflected in paragraph 2 of Article 12 of this Recommendation. Appropriate information on the purpose and nature of the intervention as well as on its consequences and risks (including where relevant those for a fetus or for a potential pregnancy) should be given prior to requesting either consent or authorisation. It is important that explanations are communicated clearly, sensitively, and in a manner that is understandable to the person receiving the information. If the use of, for example, a newly developed medication or treatment method is being considered, it may be helpful to seek an independent second opinion from another doctor on the appropriateness of the proposed intervention, and for the person providing consent or authorisation to have the opportunity to discuss the issue with that doctor. Consent should also be given freely; this is particularly important when a person is vulnerable for any reason, as discussed in

paragraph 55 above. If relevant, patients should be made aware of the importance of reporting side-effects of medication, and of methods of minimising such effects (for example by taking the medication at a particular time of day).

95. If the person (whether adult or child) does not have the capacity to consent and under normal circumstances authorisation would be obtained from a representative, consideration should be given to the possibility of conflict of interest if the representative has a close personal relationship with the person concerned. For example, when people live in the same house difficult situations may arise if the representative finds the behaviour of the person concerned unacceptable. Recommendation R (99)4 on *principles concerning the legal protection of incapable adults* emphasises that the interests and welfare of the person concerned should be the paramount consideration in the implementation of any protective measure. Thus, if it is thought that a representative is not basing his or her decisions on such principles, consideration should be given to seeking authorisation from an independent source, such as a court.
96. In some circumstances, it may not be possible to reach agreement concerning a person's treatment with his or her representative. If the doctor responsible for the person's care continues to consider that the proposed treatment is necessary, a judgment of the European Court of Human Rights in 2004 has stated that the issue should be referred to a court for resolution<sup>3</sup>.
97. Mental disorder can affect a person's capacity to consent. A person who was severely ill and, according to law, did not have the capacity to consent at the start of treatment may develop such capacity during the course of treatment. If the person's legal position changes in this way, appropriate action should be taken. For example, if the treatment had been given with the authorisation of a representative, the person's own consent would be required once the person was legally able to give it.
98. Paragraph 3 of this Article reflects the general principle on emergency situations that originates in the Convention on Human Rights and Biomedicine. As with the Convention, the principle is confined to medically necessary treatments that cannot be delayed. However, the possibility is not confined to life-threatening situations.

### **Article 13 – Confidentiality and record-keeping**

99. Article 10 of the Convention on Human Rights and Biomedicine states that "Everyone has the right to respect for private life in relation to information about his or her health" and this principle is equally applicable to persons with mental disorder. The first paragraph of this Article means that the principles of the existing data protection instruments of the Council of Europe, including the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (1981; ETS 108) and Recommendation R (97)5 of the Committee of Ministers to member states on *the protection of medical data*, will be applicable to persons with mental disorder. Data concerning a person's mental disorder or concerning a person's treatment for that disorder are forms of sensitive data and are entitled to a high level of protection. The data are entitled to the same level of protection wherever they are recorded. Articles 27 and 28 state that certain information should be recorded in a register. Therefore, such registers will include sensitive personal data that require the same level of protection as a person's medical records.
100. Situations in which mental health professionals become aware that a person with mental disorder may be a risk to identifiable other persons give rise to an ethical dilemma between the requirement to protect confidentiality and the prevention of risk to others, if a disclosure might avert such a risk. It can be noted that Principle 7 of Recommendation R (97)5 permits communication of medical data if (subject to certain other requirements) they are relevant and either:
  - The person him or herself, or his/her legal representative or an authority, person or body provided for by law has given consent; or
  - The communication is permitted by law and constitutes a necessary measure in a democratic society for the prevention of a real danger or the suppression of a criminal offence or the protection of the rights and freedoms of others.
101. Recommendation R (97)5 also allows medical data to be communicated, when provided for by law, to safeguard the vital interests of the person concerned or other persons. The medical data should only be communicated to a person subject to the rules of confidentiality incumbent upon a "health

<sup>3</sup> *Glass v United Kingdom, judgment of 9 March 2004, Application number 0061827/00*

care professional or to comparable rules of confidentiality". In the context of mental health services the communication of such data may be necessary, even if the person concerned does not consent, if the person could otherwise be at severe risk or pose a threat to public safety. The Recommendation also sets out other grounds for communication of medical data and should be consulted for further information.

102. Clear and comprehensive medical records are always important, but administrative records may only be appropriate in certain circumstances, for example when a person is subject to an involuntary measure. When patients are subject to involuntary measures, the records required by paragraph 2 can form the basis of reviews of the lawfulness of each measure and the justification for its continuation. These records should be carefully drawn up in accordance with each member state's regulations and with professional obligations and standards. They should contain the relevant diagnostic information and provide an on-going record of the patient's state of physical and mental health, including an account of all therapeutic and placement-related decisions taken, with reasons, based on objective observed or reported facts.
103. The conditions governing access to this information by patients, their representatives and where appropriate their families should be clearly specified by law, in accordance with the relevant principles of access to medical data of the instruments noted in paragraph 99 above.

#### **Article 14 – Biomedical research**

104. Biomedical research is an important basis for improvements in the understanding and treatment of mental disorder. The relevant provisions of the Convention on Human Rights and Biomedicine referred to in this Article are Articles 15, 16 and 17. Article 15 of the Convention on Human Rights and Biomedicine sets out the principle of freedom of scientific research. However, this can never be absolute, but must be qualified by the fundamental rights of the individuals that may participate in research.
105. The term "biomedical research" used in this Article has the same meaning as in the [draft] Additional Protocol to the Convention on Human Rights and Biomedicine, on Biomedical Research; it covers research into molecular, cellular and other mechanisms in health, disorders and disease; and diagnostic, therapeutic, preventive and epidemiological studies involving interventions. This list is not meant to be exhaustive.
106. The term "intervention" covers physical interventions and other interventions in so far as they involve a risk to the psychological health of the person concerned. The term "intervention" should be understood here in a broad sense, as including all medical acts and interactions relating to the health or well being of persons in the framework of health care systems or any other setting for scientific research purposes. The [draft] Additional Protocol covers all interventions performed for the purposes of research in the fields of preventive care, diagnosis, treatment, or rehabilitation. The [draft] Additional Protocol applies the definition of intervention used by the Convention on Human Rights and Biomedicine to the specific field of biomedical research. Questionnaires, interviews and observational research taking place in the context of a biomedical research project constitute interventions when they involve a risk to the psychological health of the person concerned. Questionnaires or interviews could carry a risk to the psychological health of the research participant if they include questions of an intimate nature capable of resulting in psychological harm. In this context, slight and temporary emotional distress would not be regarded as psychological harm.
107. Other types of research that may not involve people directly, such as certain epidemiological or sociological research projects, might raise ethical issues (for example concerning discrimination) and, although such projects are not within the scope of this Article or that of the [draft] Additional Protocol on Biomedical Research, the need for ethical scrutiny of such projects should be considered.
108. The potential for discrimination against persons with mental disorder in the context of biomedical research should be kept in mind. The exclusion, without clinical or scientific justification, of persons who have or have had mental disorder from research projects that could be of potential benefit to their health (for example, if the person had cancer and the research project concerned a new cancer treatment) would be one example of such discrimination.
109. Articles 16 and 17 of the Convention on Human Rights and Biomedicine set out principles that should be respected with regard to research on persons who have the capacity to consent and on

those who do not have such capacity respectively. These principles are applicable to persons with mental disorder.

110. Furthermore, the [draft] Additional Protocol on Biomedical Research includes a detailed protective provision concerning persons deprived of their liberty, which is of relevance to those subject to involuntary placement or in a penal institution. The general safeguards of the Protocol, for example independent ethical review of research projects and ensuring that undue influence is not exerted on potential research participants are particularly important in view of the vulnerability of persons with mental disorder who are deprived of their liberty for whatever reason.
111. The purpose of this Article is to draw attention to the need for any biomedical research on persons with mental disorder to respect the ethical and legal conditions appropriate to the conduct of such research, as specified in the instruments referred to in the previous paragraphs. Member states are entitled to set higher levels of protection with regard to research involving patients with mental disorder (or groups of such patients, such as those subject to involuntary measures) in accordance with Article 1, paragraph 2 of this Recommendation should they choose to do so.

#### **Article 15 – Dependents of a person with mental disorder**

112. Most people with mental disorder do not live in isolation, but have a network of social and family relationships. A partner, parents who are elderly and in poor health, and in particular young children may be dependent on a person with mental disorder. Such dependants may have emotional, educational, social and care needs. Concern about an inability to meet those needs may impair a person's recovery from mental disorder. The Article highlights the need to consider the situation of dependants. However, the Article is not intended to cover the financial needs of dependants, which should be addressed according to national law.
113. In some cases, it may be appropriate to provide assistance to the person with mental disorder so that she or he can meet his or her responsibilities to dependants. The Article does not specify that any particular person or body should be responsible for considering the needs of dependants, as such needs may vary widely. For example, different persons or bodies may need to be involved depending on whether the dependant is an elderly parent or a young child. In certain cases, the needs and interests of the person with mental disorder may conflict with those of his or her dependants (for example if contact with a parent who has a chronic severe mental disorder appears to have a significant adverse effect on a child) and the best approach to take will need to be considered carefully in the light of all the circumstances.
114. The intention of this provision is not to question the parenting or caring capacities of all persons with mental disorder. However, severe forms of mental disorder may decrease the ability of a person to meet the needs of their children. Such needs go beyond physical and health needs and include aspects of their emotional, social and educational development. If a person with children who are still minors has a mental disorder of a serious nature, particularly if that disorder is long-lasting or recurrent, this Article highlights the need to explore the impact of the person's disorder on the children. If it is appropriate, action could then be taken by the relevant persons, agencies or bodies to ensure that the children's needs are met appropriately. Such action could include supporting and providing assistance to the parent in their parenting role.

#### **Chapter III – Involuntary placement in psychiatric facilities, and involuntary treatment, for mental disorder**

115. The Chapter concerns involuntary measures in a civil or administrative context. Involuntary measures in a criminal context are dealt with in Article 34. Chapter III does not cover placements on grounds other than that of mental disorder, for example when a person with dementia is placed in a care home so that the person's needs for personal care (for example a need for assistance with dressing, washing and bathing) can be met. Article 9.2 requires that facilities for involuntary placement are registered with an appropriate authority; it is thus for member states to determine which facilities are suitable for the involuntary detention of persons with mental disorder.
116. The law may provide that measures such as involuntary placement may be used in other contexts, for example to prevent the spread of infectious disease. Although such measures are beyond the scope of this Recommendation, the vulnerability of persons with mental disorder should be kept in mind, in particular to ensure that they are not subject to discrimination in respect to the application of such measures.

- 117. The term “psychiatric facilities” should be understood in a broad sense, and includes, for example, psychiatric units in general hospitals as well as psychiatric hospitals of all types and of all levels of security. As Article 2 makes clear, the reference to facilities includes units in which a person may be placed.
- 118. As was emphasised in paragraph 25 above, persons with mental handicap should never be subject to involuntary measures based on the mere fact of the person’s mental handicap.

#### **Article 16 – Scope of chapter III**

- 119. This provision introduces the Chapter and specifies the groups of persons to whom its provisions may be relevant. Nevertheless, the mere fact that a person falls within the scope of the Chapter does not mean that the person can be subject to involuntary placement or to involuntary treatment. For a person to be subject to an involuntary measure the relevant criteria, as specified in Articles 17 and 18, and the relevant procedures of either Article 20 or 21 should be fulfilled before the measure is implemented. As discussed in paragraphs 137-139 below, the provisions of this Chapter may also be relevant when a person has been provisionally diagnosed as having a mental disorder in the circumstances set out in Article 17.2.
- 120. The criteria and procedures that should be fulfilled in order for a person to be subject to an involuntary measure are the same whether or not the person is in the community or in hospital (having entered the hospital on a voluntary basis) at the time the decision is sought.
- 121. Article 16 makes clear that involuntary measures are those that are against the current will of the person concerned. Involuntary measures should not be automatically equated with forced measures. For example, although a person with mental disorder may disagree strongly with the principle of an involuntary measure and would like to refuse it, once the decision to apply an involuntary measure has been taken the person may comply with its terms. Thus, when prescribed medication the person will take the tablets offered without resistance. However, if the person was asked whether the treatment was acceptable to him or her, the answer would be no. The proportion of patients subject to involuntary treatment who actively resist treatment is small.
- 122. Furthermore, every effort should be made to enable a person to accept voluntary placement or voluntary treatment, as appropriate, before implementing involuntary measures. The principle of least restriction implies that use of such measures should be minimised as far as possible. Article 10.ii., concerning alternatives to involuntary placement and involuntary treatment is highly relevant in this context.
- 123. The terms “have the capacity to consent” and “do not have the capacity to consent” in this Article have the same meanings as in the Convention on Human Rights and Biomedicine. Article 6 of that Convention makes clear that it is for national law to determine whether or not (under certain conditions) an adult or minor does not have the capacity to consent. In the Convention, it is considered that if a person has the capacity to consent to an intervention then the person also has the capacity to refuse it. However, when a person does not have the capacity to consent s/he does not have the capacity to refuse as such, but is able to express an objection. The wording of this Article follows the same usage.
- 124. Article 12.2 of this Recommendation provides an example of the general principle that when a person does not have the capacity to consent, authorisation for a proposed measure is sought from a representative, authority, person or body provided for by law. However, if the person objects to a proposed treatment or placement measure he or she falls within the scope of Chapter III irrespective of the views of the representative, authority, person or body and the relevant criteria and procedures should be satisfied prior to the implementation of a measure. In the case of young children it is necessary to evaluate their attitude in the light of their age and degree of maturity.
- 125. The references to “are refusing” and “are objecting” in this Article emphasise that it is the person’s current attitude to the measure that should be assessed. The fact that a person has, for example, refused a proposed measure some time ago does not mean that it should be assumed that the person would refuse a renewed offer of the same measure. The person’s current attitude should be established. The reference to “placement or treatment” makes clear that the person’s consent or refusal to placement and to treatment are separate questions. A person might refuse a proposed placement, but consent to the proposed treatment, or vice-versa. The fact that a person has been subjected to involuntary placement should not lead to the assumption that they lack capacity to consent to treatment.

- 126. The scope of this Chapter does not prevent the use of involuntary measures in circumstances where a person recurrently changes his or her mind about whether or not to accept a measure, as a result of which a consistent therapeutic programme cannot be maintained, if the relevant criteria and procedures for the measure concerned are satisfied.
- 127. Although the title of the Chapter make clear that the references to placement and to treatment in this Chapter refer to placement and treatment in relation to mental disorder, the physical health care needs of persons subject to involuntary measures must not be forgotten. Article 10.iv. of this Recommendation requires that such needs are assessed and that the persons concerned are provided with equitable access to services of appropriate quality to meet such needs.

#### **Article 17 – Criteria for involuntary placement**

- 128. The first indent of paragraph 1 of this Article requires a person to have a mental disorder. However, involuntary placement is in general only considered appropriate with regard to certain types of mental disorder, for example psychoses or other severe mental disorders. Clinical experience suggests that people who abuse alcohol and drugs have generally not shown a sustained response to involuntary placement or treatment. However, in some circumstances where the risk of harm to the person him- or herself appears very high, the question of an involuntary placement in the interest of harm reduction (even if the benefit is not long-term) may be considered. The situation is very different if the person develops a mental disorder, such as a psychosis, linked to the use of psychoactive substances. Involuntary measures in relation to the use of alcohol or psychoactive substances alone should be used with great caution and on the advice of medical specialists in the treatment of people who misuse alcohol or psychoactive substances.
- 129. The second indent of paragraph 1 means that an assessment of risk must be made. Such risks can be physical or psychological. It is recognised that risk assessment is not an exact science and that no judgment on this matter can be infallible. In some circumstances, where the potential risk of harm from a threatened action (for example, significant arson) is great, involuntary placement may be appropriate even if the probability of the harm occurring is thought to be lower than would be regarded as appropriate in circumstances where the risks were more limited.
- 130. The methods by which harm may occur are very varied. As well as direct threats of harm to others or to the person him or herself, other actions may present indirect risks of serious harm to persons. Some examples include the burning of cars (the possibility that a small child is in the car cannot be excluded), setting fires in forests (in which people may be trapped) or a person running naked down the street whose speech or other behaviour suggested mental disorder (where there may be a potential risk to the person's health). In some States, these examples would be covered by a provision concerning public order or the environment. Nevertheless, the underlying principle is that of risk to persons and hence such risks are covered by the second indent. The concept of harm to other persons can also, more rarely, cover situations when persons may be put at risk by effects on their personal property that are comparable to those of personal harm; for example, if a patient with mania attempts to give away the property or the money of his family. However, it should be emphasised that petty damage to material goods should not be considered as sufficient. Similarly, if the only risk is a financial one – for example when a pathological gambler spends his family's money – then involuntary measures designed to address mental disorder are not appropriate for addressing economic risk to others.
- 131. The concept of health should be understood in a broad sense. For example, a person who is so gravely disabled by mental disorder that the person is unable to care for him or herself can be viewed as putting his or her health at risk. However, whether the degree of self-neglect was sufficient to fulfil the requirements of indent ii. would need to be assessed in the light of the particular situation.
- 132. The third indent requires that a placement include a therapeutic purpose. It must not be for political, moral, economic or social reasons or for custodial purposes only. If the purpose of a placement is solely custodianship this should not take place in a psychiatric facility. However, the fact that a placement may have additional purposes, such as the protection of others, is not excluded by this indent.
- 133. Further, a “therapeutic purpose” should not be equated with invasive medical treatment. In a therapeutic situation, the person may be offered a range of measures, such as group therapy or rehabilitation (see paragraph 91 above) that may potentially benefit their condition. However, a person subject to involuntary placement is not compelled to accept such offers. On the other hand, if no therapeutic offers were made to a person that would be evidence of the lack of a therapeutic

purpose to a placement. Similarly, lack of therapeutic success should not be equated with lack of therapeutic purpose. For example, if a range of methods of treatment have been tried without success, a therapeutic purpose still exists if the person is receiving therapeutic offers, even if the available treatments may not be able to completely cure the person's condition.

134. It is therefore good practice that when a person is subject to involuntary placement a treatment plan is established as soon as possible with the person concerned and the person's personal advocate or representative, if any. Article 12 of this Recommendation and paragraphs 90-98 of this Report provide further relevant information.
135. The fourth indent covers both the situation in which under no circumstances would it be possible to care for a person, taking into account the risk to the person or to others, other than by using involuntary placement; and the situation in which it might be theoretically possible to care for a person in a less restrictive manner but that the means to do so are simply not available. The concept of care in this indent is broad, covering both the provision of care for the person's mental disorder and ensuring the safety of the person, or where relevant others, whilst such care is provided. Whilst recognising the limitations to available resources, the requirement in Article 10.ii. to make alternatives to involuntary placement as widely available as possible is highly relevant in this context.
136. The final indent of paragraph 1 recognises that, in particular when the decision concerns risk to the patient him or herself, certain patients may recognise the risk and still prefer to take it than be subject to involuntary placement. The balance between respecting self-determination and the need to protect a person with mental disorder can be difficult, and hence it is emphasised that the person's own opinion should be explicitly considered on the issues relevant to the possible placement. For example, particularly where there is concern about the risk to the person him- or herself, s/he may have views both about the level of risk and how it might be best to address it.
137. At first contact with a person not known to a mental health service whose behaviour is strongly suggestive of a mental disorder, it is not always possible to determine immediately whether the behaviour is definitely due to mental disorder or arises from another cause. In such cases, a provisional diagnosis of mental disorder may be made. If the conditions of paragraph 2 are satisfied the person may be subject to involuntary placement for the purposes of assessment according to the procedures set out in Articles 20 or 21.
138. Article 17 emphasises that the placement should be for the minimum period necessary to make the assessment. If the assessment concludes that the person has a mental disorder that represents a significant risk of serious harm to his or her health or to other persons, consideration may be given to the prolongation of involuntary placement if the criteria set out in paragraph 1 of Article 17 are satisfied.
139. As noted in paragraphs 19 and 119 above, relevant provisions of the Recommendation, in particular those of Chapter III, will be applicable to the person during this period (for example, those concerning the right to reviews and appeals and to information).

#### **Article 18 – Criteria for involuntary treatment**

140. The first two indents of this Article parallel those of Article 17, and paragraphs 128-131 above are therefore also relevant to this Article.
141. The third indent emphasises the need to consider whether less intrusive means of providing care to the patient - for example by the use of psychotherapy or psychosocial treatments - would be sufficient to address the identified risks taking into account the risk to the person or to others. In accordance with the principle of least restriction, such measures should be considered before resorting to involuntary treatment, which should remain exceptional.
142. In respect of the fourth indent it should be noted that the right to self-determination is particularly important in the context of long-term use of medication. Some patients may prefer not to take medication at all, but to live with some symptoms of their illness. Others may be willing to take a certain amount of medication, but live with some symptoms (such as hearing voices), if complete symptom control required a higher level of medication associated with a level of sedation the person found unacceptable. A difficult balance has to be struck, and the person's opinion on the different therapeutic alternatives must play a full part in finding that balance. This does not imply that the patient's opinion must always be followed.

143. It should be noted that this Article does not make provision for involuntary treatment when a person has only been provisionally diagnosed as having a mental disorder. In such cases, in emergency situations Article 12.3 may be applicable. It should be noted that in accordance with professional standards, treatment in an emergency situation is not confined to a single intervention (such as a dose of medication) but also, where appropriate, to subsequent interventions to prevent the emergency situation recurring while the relevant consent or authorisation is sought in accordance with Article 12.2.

#### **Article 19 – Principles concerning involuntary treatment**

144. The first indent of paragraph 1 emphasises that involuntary treatment should address clinical signs and symptoms, which may include behaviour arising from a mental disorder. The reference to “therapeutic purpose” should be understood according to paragraphs 132-133 above; for example it must not be a response to a family or social need alone. In some cases, it may not be possible for treatment to completely alleviate a condition, but preventing further deterioration should also be understood as a therapeutic purpose.

145. It is recommended that only officially recognised pharmaceutical products should be used involuntarily and that in view of reports of extensive, and frequently excessive, uses of medication, side effects and dosage regimes should be carefully monitored. Doses of medication should be reduced as soon as therapeutically appropriate. In the context of involuntary measures concern has been expressed about what is sometimes called “chemical restraint”. Medication is used as a restraint if it is used to control the person’s behaviour, is not medically necessary, and is not a clinically appropriate treatment for the person’s condition. Medication should never be used for the convenience of staff or as a means of coercion, discipline, or punishment.

146. The treatment plan referred to in paragraph 1.iii. should also include other potentially therapeutic measures (see paragraph 91 above). When a person is subject to involuntary treatment, it is also good practice for the treatment plan to be subject to an independent review, for example by an independent doctor. In some countries, involuntary treatment is recorded in separate registers in addition to the medical and administrative records referred to in Article 13.2. Such an approach facilitates the independent monitoring of the use of involuntary treatment and may be regarded as good practice.

147. The reference to the involvement of a personal advocate or representative in the second paragraph is in response to the vulnerability that persons who are subject to involuntary treatment may feel in discussions about their treatment, in particular with the doctor responsible for their care. The presence of the personal advocate or representative may provide moral support and help the person express his or her real views.

148. Any treatment should be delivered in accordance with professional obligations and standards. This is particularly important if it is delivered involuntarily outside a medical facility. Paragraph 3 emphasises that involuntary treatment should only take place in an appropriate environment. Any necessary medical monitoring or other support required for the administration of the treatment must be available.

149. The administration of involuntary treatment to a person who actively resists it is not recommended outside a medical facility.

#### **Article 20 – Procedures for taking decisions on involuntary placement and/or involuntary treatment**

150. Although involuntary placement and involuntary treatment are covered in this Article because of the similarity of the relevant procedures, the intention is that these measures should be considered separately. However, the fact that both types of measure might be considered at the same time is not excluded. Thus, in administrative terms, a decision on involuntary placement and a decision on involuntary treatment may be combined in a single administrative or judicial decision and subject to a single appeal procedure.

151. Paragraph 1 requires the decision on placement to be taken by a court or another competent body. The underlying principle is that a party that is independent of the person or body proposing the measure takes an independent decision. The body that takes the decision must be satisfied that the criteria in Article 17 are met.

152. Both paragraphs 1 and 2 emphasise that the court or competent body should act in accordance with procedures provided by law. These should comply with the guarantees of the European Convention on Human Rights and should be based on the principle that the person concerned should be seen and consulted. Such consultation enables the court or other competent body to form an independent view of the situation. This contact could be delegated to an official of the court or competent body and would not have to take place in the courtroom or at the site of the competent body, but could be in the person's home or in another place of safety.

153. Paragraph 2 sets the framework in which the decision of principle is taken on whether or not a person should be subjected to involuntary treatment. In order to provide guarantees against possible abusive use of involuntary treatment by doctors, the provision ensures that a court or competent body will always be involved at some stage, either by taking the decision on involuntary treatment itself or, according to the legal system concerned, taking the decision on involuntary placement and then allowing the decision on involuntary treatment to be taken by a doctor. The person or body that takes the decision must be satisfied that the criteria in Article 18 are met. If the national legal system requires the decision to be taken by a court or competent body the provision does not require the court or other competent body to approve, for example, each individual dose of medication to be given.

154. With regard to the second part of paragraph 2, if the doctor responsible for the care of a person subject to involuntary placement is allowed by law to take decisions about involuntary treatment then that doctor would previously have seen and consulted the person. However, the law might provide that only particular doctors, for example the chief doctor of a hospital, could take such decisions. Such a doctor might have had no prior contact with the person concerned, and therefore the second part of paragraph 2 includes a reference to seeing and consulting that person.

155. Paragraph 3, which provides that a review period for a decision should be specified, implies that the validity of any decision must be subject to a time limit, which will be set by national law. However, this is without prejudice to the person's rights to reviews and appeals in accordance with the provisions of Article 25.

156. Paragraph 4 requires the person concerned to be examined by a doctor having the requisite competence and experience. In non-emergency situations this doctor would normally be a psychiatrist. One of the most important competences required is in assessing the risk to the person concerned or to others if an involuntary measure is not applied. The provision does not exclude the relevant doctor receiving information from other health care professionals who have personally examined the patient. The provision reflects the case law of the European Court of Human Rights, which requires involuntary detention to be based on objective medical expertise.

157. The purpose of the general rule in paragraph 5 to consult those close to the person is to support good professional practice. Those close to the person may be aware of other information, including the person's background and culture, which may alter the opinions held on a person's mental state. The requirement may therefore help to prevent a person being subject to an inappropriate measure. On the other hand, in some circumstances the interests of those close to the person and the person him or herself may not coincide and those close to the person may wish, for their own reasons, the person to be subject to an inappropriate measure. In some circumstances a measure may be so obviously necessary that an absolute requirement for such consultation would be unduly bureaucratic.

158. Although paragraph 5 includes the principle of respecting the patient's objection to consultation of those close to him or her, it is recognised that in clinical practice there may be circumstances in which it is very difficult to make an assessment of the person's potential risk to others and it is desirable to consult those close to the person to improve the accuracy of the risk assessment. Such rare situations have to be considered on an individual basis. The provision does not prevent the doctor or the competent body receiving information spontaneously offered by those close to the person concerned.

159. The intention of paragraph 6 is that if the person concerned, or those close to him or her, informs the doctor or the competent body that the person has a representative who has been appointed by law to take decisions on behalf of, and represent the interests of, the person concerned then that representative should be consulted about the person's condition and about the proposed measure. An exhaustive search to attempt to determine whether such a person exists is not required. Reasonable efforts to contact a representative if one is known to exist should always be made. However, there is no intention to render the procedure unlawful if in fact contact cannot be made (for example if the representative is on holiday and no contact details are available). If the person

already has a personal advocate (see paragraph 52 above) then, if the person so wishes, it would be good practice to allow the personal advocate to support the person during the relevant procedures. The possibility of offering a person who has no personal advocate the opportunity to choose such a person at this point is not excluded.

### **Article 21 – Procedures for taking decisions on involuntary placement and/or involuntary treatment in emergency situations**

160. In an emergency situation an immediate serious risk to the person concerned or to others appears to exist and the delay entailed in applying normal procedures would therefore be unacceptable. Procedures designed for such situations should not be used in other circumstances. In such situations it may not be possible to obtain an opinion from a psychiatrist. In these situations, paragraph 2.i. permits the decision to be based on a medical assessment appropriate to the measure concerned taking into account the circumstances. The case law of the European Court of Human Rights specifically identifies involuntary placement in emergency situations as not requiring thorough medical examination prior to the placement<sup>4</sup>.
161. Therefore the examination may be brief, or even conducted through a door if the person has barricaded himself into a property, but nevertheless sufficient information must be obtained to satisfy the criteria for the measure concerned.
162. In some cases, the requirement for an involuntary measure may be very brief. As specified by Article 24.1, if any of the criteria for a measure are no longer met the measure should be terminated. It is thus possible, at least theoretically, for a measure to be terminated before the court or another competent body could have taken a decision in accordance with Article 20. As specified in paragraph 1 of this Article, procedures for emergency situations should not be used to avoid applying the procedures set out in Article 20.
163. Paragraph 2.i. emphasises that an involuntary measure applied under emergency procedures should be for a short period of time (for example, a maximum of 48 or 72 hours). If the measure needs to be continued beyond that time, the procedures set out in Article 20 should be followed.
164. The fact that a decision has been made in an emergency situation does not limit the right of the person concerned to appeal against the lawfulness of the measure according to Article 25 of this Recommendation.

### **Article 22 – Right to information**

165. Patients subject to involuntary measures are entitled to the same information about their rights as patients as specified in Article 6. Because of the infringement of the person's rights and freedoms entailed by involuntary measures, this Article specifies that they should be given the information both verbally and in written form. This information must include information on their rights to reviews and to appeal against the measure concerned according to Article 25 of this Recommendation. In accordance with the European Convention on Human Rights, a person subject to involuntary placement should also be promptly informed about the reasons for the involuntary placement<sup>5</sup>.
166. If further or new information becomes applicable, for example, concerning specific rights that only become relevant after a particular duration of an involuntary measure, or regarding a change in the law, that information should be given to the person in a timely manner.
167. In respect of involuntary treatment, the Article does not require that the patient receive this information every time she or he receives, for example, a dose of medication. The information should be given at the commencement of involuntary treatment, and subsequently information should be provided in accordance with paragraph 2.
168. Paragraph 3 specifies that the person's representative, if any, should also be given the information referred to above. It is good practice to give that information both verbally and in writing.

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<sup>4</sup> *X v United Kingdom*, judgment of 5 November 1981, Application number 00007215/75

<sup>5</sup> *van der Leer v The Netherlands*, judgment of 21 February 1990, Application number 00011509/85

## **Article 23 – Right to communication and to visits of persons subject to involuntary placement**

169. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has highlighted the importance of those subject to involuntary placement being able to communicate with the outside world, both from a therapeutic standpoint and as a safeguard against abuse. It is not envisaged that it would ever be appropriate to restrict correspondence with the persons or bodies listed in the first sentence of indent i. Appropriate authorities include those charged with monitoring standards according to Article 37 of this Recommendation and international bodies such as the European Court of Human Rights and the CPT. The patient's right to receive information from outside the placement facility should not be restricted.
170. Restrictions on the right to communicate with other persons should be exceptional. Such restrictions should only aim to:
  - protect the rights of others (for example if the patient is making or sending repeated unpleasant telephone calls or letters to members of the family or other acquaintances);
  - prevent harm to the future prospects of the person concerned (for example if a mentally ill person indicates that s/he intends to resign from his or her job, but is not considered to have the capacity to make that decision);
  - prevent offences (for example if the patient was suspected of drug-trafficking, some degree of censorship might be imposed). The patient should be informed of any such restrictions in order to allow him or her to challenge them in a court or before a competent body.
171. Any psychiatric facility should have "house rules" in relation to communication and visiting that should be subject to appropriate independent scrutiny. These should cover matters such as the use of the telephone, visiting times and the circumstances (if any) in which measures such as the searching of patients and their rooms, random urine drug tests and monitoring of patients' phone calls could be applied.
172. The Article does not exclude the possibility, where necessary and appropriate, for communications to be subject to some form of surveillance or monitoring. One example might be if a person was suspected of being involved with serious criminal offences with the person he has named as his personal advocate.

## **Article 24 – Termination of involuntary placement and/or involuntary treatment**

173. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment specifies that involuntary placement should cease as soon as it is no longer required by the patient's mental state. This Article follows that principle, which is based on the case law of the European Court of Human Rights<sup>6</sup>.
174. The reference to "the responsible authority" in paragraph 3 refers to the authority responsible for the facility in which the patient is placed, or where the patient is receiving treatment without being subject to voluntary or involuntary placement, the authority with administrative responsibility for the doctors administering the treatment.
175. Paragraph 4 of this Article relates to the principle in Article 10.ii. that alternatives to involuntary measures should be made as widely available as possible. After-care provision that links hospital and community services, and which is able to provide more intensive support immediately after the discharge of a patient from hospital, may allow the patient to be discharged from involuntary placement earlier than would otherwise be the case.

## **Article 25 – Reviews and appeals concerning the lawfulness of involuntary placement and/or involuntary treatment**

176. The jurisprudence of the European Court of Human Rights makes clear that the European Convention on Human Rights means that a person has the right to appeal against, or to have reviewed, decisions concerning involuntary placement or involuntary treatment (or, if applicable, both) at reasonable intervals<sup>6</sup>. If a competent body has taken a decision, a court should decide an

<sup>6</sup> *Winterwerp v The Netherlands*, judgment of 24 October 1979, Application number 00006301/73

appeal against the decision promptly. If a court took the original decision, a court should also decide an appeal.

177. This Article takes into account the requirements of Article 5 of the European Convention on Human Rights in respect of deprivation of liberty, and the standards laid down by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, in particular with regard to the right to review. If the court finds that the placement contravenes the legislative provisions in force, the person concerned should have the right to compensation as provided for in Article 5.5 of the European Convention on Human Rights which states: "Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation."
178. Whether an interval is "reasonable" in accordance with paragraph 1.ii. has to be considered in the context of the particular circumstances, taking into account the complexity of the case, and the conduct of the applicant and that of the authorities. For example, if a mentally disordered person has requested a review and the review has concluded that the measure should be continued, if the applicant makes another application for review the day after the decision of the first review, account has to be taken of the likelihood of a new review reaching a different conclusion within a short time-frame in the context of the patient's condition.
179. Any review or appeal should use adversarial procedure (which refers to the opportunity for a party to have knowledge of and comment on the observations filed or evidence adduced by the other party). However, proceedings in a criminal context (dealt with under Article 34) and in a civil context may be seen as rather different in nature. Hence, the most appropriate form of representation for the person concerned may differ between these contexts.
180. It is good practice to inform the doctor responsible for the person's care of the relevant proceedings and of the doctor's right to participate in them.
181. The court should, in full knowledge of the relevant factual and legal issues, review whether the relevant procedural requirements and criteria for a measure or its continuation are all met.
182. The person should always be entitled to be supported by his or her personal advocate (if he or she has one), or by his or her representative (if she or he has one).
183. In respect of paragraph 2, review at reasonable intervals is important in ensuring compliance with the European Convention on Human Rights. The jurisprudence of the European Court of Human Rights makes clear that review could be undertaken by a specialist body that has the characteristics of a court – for example, if it has the necessary independence, offers appropriate procedural safeguards, and is able to decide on the lawfulness of the measure and order its termination if necessary<sup>5</sup>.
184. The law may allow the responsible authority (see paragraph 174 above) to delegate the task of informing the court to the doctor responsible for the person's care. The role of the responsible authority could in this case also be fulfilled, according to national legal systems, by a body that is not purely administrative, but also has monitoring roles. The responsible authority can also take action to initiate an early review if it considers this to be appropriate.
185. This Article covers civil and administrative proceedings. In such contexts, paragraph 5 refers to the possibility of certain information being withheld from the patient on grounds of the confidentiality and safety of others in accordance with national law. In particular, this is designed to ensure that those close to the patient can give information to the clinical team about the patient's condition (for example if the patient has had a period of home leave) in confidence if they wish to do so. In some cases, a person with mental disorder may react violently to a family member who has disclosed information that suggests the patient is not as well (and hence not as suitable for discharge) as the patient would like to appear.
186. As noted in paragraph 150 above, the appropriateness of involuntary placement and of involuntary treatment should be considered separately, but where a person is subject to both types of measure it may be convenient for a review or appeal to review both measures at the same time. In administrative terms, the outcome of the review or appeal on involuntary placement and on involuntary treatment may be combined in a single administrative or judicial decision.

## **Chapter IV – Placement of persons not able to consent in the absence of objection**

### **Article 26 – Placement of persons not able to consent in the absence of objection**

187. Different countries consider the situation in which a person does not have the capacity to give consent in different ways. In some countries, every measure applied to such persons is considered “involuntary” because the person has not consented to it. Other countries reserve the term “involuntary” for a measure that is against the person’s will, when the person has the capacity to consent and refuses the measure, or does not have the capacity to consent and objects to it. This Recommendation uses the term “involuntary” in the latter, narrower sense.
188. This Article addresses the vulnerability of those who do not have the capacity to consent, but who do not object to a proposed measure of placement that others consider necessary, when it is particularly important that the person’s interests and welfare be adequately protected. This situation is most likely to occur with respect to persons with advanced dementia or significant mental handicap, although it may also more rarely be relevant to persons with other severe forms of mental disorder. This Article highlights the need for the State to have appropriate protective mechanisms in place; different mechanisms may be appropriate for different groups of persons with mental disorder, or for placements in different types of facilities. Examples may include, where appropriate, regular reassessment of the person’s capacity or of the appropriateness of the placement.
189. It is important to ensure that if after having been placed the person indicates objection to the placement that the full provisions of Chapter III are applied. The other provisions of the Recommendation remain applicable at all times.
190. The group of people covered by this Article are also vulnerable in relation to health care interventions. This is regulated by other legal instruments, such as the Convention on Human Rights and Biomedicine.

## **Chapter V – Specific situations**

### **Article 27 – Seclusion and restraint**

191. This Article addresses physical and mechanical restraint. The use of medication as a “chemical restraint” is considered in paragraph 145 above. Paragraph 86 above emphasises the importance of minimising the use of restraint and seclusion. Seclusion and/or restraint should never be used for the convenience of staff or as a means of coercion, discipline, or punishment.
192. The reference to restraint in this Article is not intended to cover restraint that is momentary – an expression that should be interpreted strictly. The need for momentary restraint may arise, for example, in the care of a person with advanced dementia who attempts to leave a hospital ward every time the door is opened. If leaving the ward would present risks to the person’s health or safety, momentary gentle restraint may be required whilst the door is shut.
193. If momentary restraint were necessary on a regular basis it would be good practice for the need for such restraint to be recorded and be subject to medical supervision in the context of the patient’s treatment plan.
194. Seclusion, or restraint that is more than momentary, should always be used in the context of a treatment plan. As specified in paragraph 1, they should only be used in appropriate facilities, such as a hospital. The use of more than momentary restraint in elderly persons may have a higher level of risk than in younger patients and additional safeguards may be advisable for this group of patients.
195. If it is recognised that such measures may be necessary, it is good practice to discuss this with the patient if it is possible to do so, and to take into account the patient’s views. For example, a patient may be aware that he or she has a tendency to become violent in certain circumstances. In a period in which the person is calm, it may be possible to discuss how the person would like to be approached if staff recognise the signs that violence may be imminent. The person might prefer to go to the seclusion room of his own volition for a short period, and remain there with the door to the room open, to enable him to become calmer and prevent the possible need for restraint should the situation escalate.
196. The reference to the principle of least restriction (Article 8) in the first paragraph of Article 27 makes clear that staff should respond to threatened or actual violent behaviour by a person with mental

disorder in a graduated way; firstly by responding verbally; thereafter, only in so far as required to prevent immediate or imminent harm to the patient or others, by means of manual restraint; and only in the very rare cases where it can be justified, and as a last resort, by mechanical restraint. The principle of least restriction also implies that the duration of the measure should be no greater than is necessary to achieve the purpose. The example of the replacement of the use of cage beds with less restrictive interventions given in paragraph 82 above is also relevant to this Article.

197. The references to harm in this Article include the potential infliction of pain. The reference to harm to the patient him or herself covers, for example, situations in which a patient has a knife and attempts to stab himself with it (or appears to intend to try to do so), or has prepared a noose and is trying to hang himself.
198. The requirement for supervision does not mean that a doctor needs to be present at the commencement of a measure, which may need to be applied in an emergency situation. Although the Article does not address momentary restraint, because seclusion or restraint can be regarded as decisions of a medical nature, it is good practice for the doctor to be aware of the frequency with which momentary restraint is being used in order to review its appropriateness and consider whether any less restrictive intervention might be used as an alternative.
199. Persons who have been subject to seclusion or restraint have described very negative feelings about their experience, including feelings of humiliation and loss of dignity. It is important to ensure that any person who has been subject to more than momentary restraint or to seclusion is given the opportunity to discuss the experience with clinical staff. Such debriefing can address any negative feelings about the experience and explore approaches that may minimise the future need for seclusion or restraint.
200. The Article takes into account, in particular, the recommendations made in the published reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The CPT emphasises that seclusion and restraint should never be used as a punishment, and that seclusion or restraint of patients should only be used in the context of clearly defined institutional policies.
201. The requirement in paragraph 2 for appropriate documentation aims to ensure that the use of seclusion and restraint can be monitored. Article 37.1.ii. of this Recommendation highlights the importance of monitoring compliance with professional obligations and standards. Appropriate records of the use of restraint and seclusion, including the use of a register as discussed in paragraph 202 below, will assist in achieving this objective.
202. Paragraph 3 of the Article sets more detailed standards for recording the use of seclusion or restraint for more than a short period. It is difficult to define exactly what constitutes a "short period" but the intention is to refer to a period of no more than a few minutes of physical restraint. This period should be interpreted strictly; given the impact of seclusion or restraint on the persons concerned it is important that if the use of a measure cannot be avoided, then its use is associated with a high level of safeguards. It is good practice to record every instance of restraint that is more than momentary, and every use of mechanical restraint.
203. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Standards require that every instance of physical restraint or use of seclusion is recorded in a specific register established for this purpose as well as in the patient's medical file. The entry should include the times the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff. The CPT emphasises the importance of such registers in monitoring the extent of the use of such measures. In a prison context, the CPT requirements only refer to the use of mechanical restraint. Each State should ensure that the responsibility for organising and maintaining the register is clear. In practice, it is likely that such registers will be held in the relevant facilities. The register will contain sensitive personal data and as noted in paragraph 99 should be protected accordingly.
204. Seclusion or restraint may be used in penal institutions or by the police for reasons unrelated to mental disorder. Examples include the maintenance of good order in the institution or to prevent a person escaping. The use of seclusion or restraint for reasons other than mental disorder are beyond the scope of this Recommendation, although persons with mental disorder should not be subject to discrimination in the use of such measures. Where seclusion or restraint is used in a penal institution in relation to a mental disorder, the principles of Article 27 should be followed taking into

account appropriate security considerations. Security considerations may also be relevant when persons are subject to involuntary placement in high security psychiatric facilities.

### **Article 28 – Specific treatments**

205. Paragraph 1 refers to treatments that are not aimed at producing irreversible physical effects but may be perceived as particularly intrusive. Such treatments may not be particularly invasive in a physical sense. Member states are responsible for deciding which treatments fall within this category, taking into account international views (for example, as expressed by the World Psychiatric Association). They are also responsible for determining the ethical scrutiny that is appropriate to treatments covered by this paragraph. Such scrutiny could, for example, be carried out in the context of developing national law that regulated the treatment, or by a professional body in the course of developing professional guidance on the appropriate use of the treatment.
206. Electroconvulsive therapy (ECT) is a treatment that might be considered to fall within this category. ECT has strictly defined and limited medical indications, and can be a life-saving treatment when used for those indications (for example, it may be the most rapid way to achieve improvement in a profoundly depressed patient who is failing to eat and drink because of their depression and whose physical health is at severe risk). In such circumstances the person is unlikely to have capacity to consent because of the severity of their illness, and hence paragraph 1.iii. makes provision for the person to receive a potentially life saving treatment in those circumstances with the safeguard of independent review of its appropriateness.
207. The reference in paragraph 1 to “international standards and safeguards” refers both to the need to take account of developments internationally and to international views on certain treatment approaches. In particular, attention is drawn to the view of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) that:

“The CPT is particularly concerned when it encounters the administration of ECT in unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.”
208. The CPT Standards also require any use of ECT to be recorded in detail in a specific register. This assists in ensuring that appropriate monitoring can take place and that any undesirable practices can be identified. The register will contain sensitive personal data and as noted in paragraph 99 should be protected accordingly.
209. The use of specific treatments covered by Article 28 on minors requires particular consideration. In the preparatory work on this Recommendation no circumstances in which it would be appropriate to use an irreversible intervention such as psychosurgery for the mental disorder of a minor were identified.
210. Paragraph 2 of this Article covers treatments for mental disorder that aim to produce irreversible physical effects. Such treatments are very rarely used in psychiatric practice, and should only be used, in accordance with the principle of least restriction, as a last resort when all other treatment options have failed, and with the person’s informed, written consent.
211. An example of an intervention aimed at producing an irreversible physical effect would be a psychosurgical operation where the intention is to produce a small lesion at a specific site in the brain. Such a lesion will have an effect on the functioning of the brain. The intended effect is an improvement in the person’s mental disorder. However, in the same way that medication can have unintended side-effects, it is possible for such lesions to produce unintended functional effects. Modern psychosurgical techniques, where the lesions produced are very small indeed, reduces the risk of adverse functional side-effects. However, the risk of such side-effects should be fully covered in the process of seeking consent.
212. Paragraph 2 states that such treatments should not be used on a person subject to involuntary placement, in particular because of the difficulty of ensuring that any consent given in those circumstances was voluntary.

- 213. The requirement in paragraph 2 for free, informed, specific and written consent by the person concerned means that authorisation cannot be given on behalf of a person who does not have the capacity to consent (whether a minor or an adult) to an irreversible treatment for mental disorder.
- 214. Member states are responsible for determining the nature of the ethical scrutiny referred to in paragraph 2.ii.
- 215. Clinical protocols, as referred to in paragraph 2.v., are designed to ensure that an intervention is in accordance with professional standards. Such a protocol could cover the treatments that should be used, and the duration for which they should be used, prior to a person being considered for psychosurgery. Psychosurgery should only be used if such treatments are ineffective. The protocol should also cover the tests, including physical and psychological tests and imaging studies, which should be carried out prior to the intervention. Such protocols are complex, and this paragraph should not be regarded as a comprehensive account.
- 216. The reference to “international standards and safeguards” in paragraph 2.v. is based on the fact that, for example, psychosurgery to treat serious mental disorder is now rarely carried out, and only for very limited medical indications. Few centres have expertise in this type of intervention. It is therefore important that if such treatment is proposed, the doctors responsible for carrying it out take full account of the reported experience of other centres round the world to ensure that any treatment given is in accordance with the most up to date practice. In view of the lack of long term studies of the effects of modern psychosurgical techniques it is important that centres that perform such interventions are supported in carrying out such studies. The requirement for such interventions to be recorded in a register aims to facilitate both monitoring of the use of such interventions and further investigation of their effects. The register will contain sensitive personal data and as noted in paragraph 99 should be protected accordingly.
- 217. Paragraph 2 does not cover treatments that may, as an unintended side-effect, have irreversible effects. For example, certain drugs used to treat psychosis may produce the potentially irreversible condition tardive dyskinesia in a proportion of patients after long-term use. However the doctors prescribing such drugs do not intend to produce such an effect.

### **Article 29 – Minors**

- 218. Minors may be placed in a wide range of facilities, including foster homes and community homes as well as hospitals. Member states have different definitions of a “minor”. With regard to this Recommendation, as is the case for the Convention on Human Rights and Biomedicine, it is for member states to define how the term is to be interpreted. The reference to considering the minor’s opinion in paragraph 2 of this Article reflects the general requirement of Article 6.2 of the Convention on Human Rights and Biomedicine on this point.
- 219. With respect to paragraph 3, although a parent would normally be the representative of a minor, in some cases the interests of the minor and the parent may conflict. Where the views of the minor and those of the parent conflict, consideration should be given to making another representative (for example, a social worker could fulfil this role) available to the minor who the minor trusts to represent his or her interests.
- 220. In respect of paragraph 4 an example would be where the minor’s interests and welfare would be better served by admission to an adult unit close to home - thus promoting contact with the family - rather than to a child and adolescent unit a long way from home.
- 221. Paragraph 5 reflects the principles of Article 28 of the United Nations Convention on the Rights of the Child (1989) that provides for a child’s right to education, and that such education should be available and accessible to all children. The teaching may be organised by the relevant education departments in association with the managers of the mental health facility concerned. The reference to training in this Article includes vocational training.

### **Article 30 – Procreation**

- 222. Article 12 of the European Convention on Human Rights specifies that “Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.” As stated in Article 4.2 of this Recommendation, any restriction on that right should be in conformity with the provisions of the European Convention on Human Rights.

223. Article 30 stresses the principle that mental disorder in itself does not constitute a justification for the permanent infringement of a person's capacity to procreate (sterilisation). Sterilisation is not a treatment for mental disorder. Although modern methods of sterilisation are in many cases potentially reversible, the Article is aimed at any intervention intended to be permanent notwithstanding that there might be a possibility of reversal by surgical means.

### **Article 31 – Termination of pregnancy**

224. The criteria under which States permit or prohibit termination of pregnancy is beyond the scope of this Recommendation. This Article stresses the principle that a person's mental disorder, in itself, should not constitute a justification for termination of her pregnancy. Without prejudice to the position of any State on termination of pregnancy, it should be noted that if a woman considers that the effects on her of a mental disorder are such that she does not wish to continue a pregnancy, the justification proposed in that case is not the mere fact of a mental disorder.

## **Chapter VI – Involvement of the criminal justice system**

225. Persons with mental disorder involved with the criminal justice system are entitled to the rights laid down in the European Convention on Human Rights. The rights laid down in Articles 5 and 6 of that Convention are of particular importance in this context, and the provisions of this Chapter should be read in the light of those Articles.

### **Article 32 – Involvement of the police**

226. Interventions according to paragraph one may include arrest or entry into premises according to national law. The purpose of the requirement in paragraph one to coordinate interventions (both in public and in private areas) with those of medical and where relevant social services is to ensure respect for the dignity, interests and welfare of the person concerned. Such coordination is also good practice when a person is suspected of a criminal offence and his or her behaviour is strongly suggestive of mental disorder, even when there does not appear to be a risk of significant harm to the person or to others.

227. The requirement in paragraph 2 is considered to be part, where appropriate, of the general role of the police, as the guarantor of respect for the security of persons and for public order.

228. Members of the police are members of the criminal justice system and all their activities should be seen as being part of that system. They have a duty to respect the dignity and fundamental rights of persons with mental disorder from the time they commence their duties. This duty should be reinforced during training. However, not having undertaken specific training does not excuse a member of the police from the need to respect the principle.

229. In particular, attention is drawn to Recommendation Rec (2001)10 on the *European Code of Police Ethics* and to its Explanatory memorandum. It emphasises the need for the police to give particular attention to the situation of vulnerable groups of people, and sets specific standards concerning arrest and deprivation of liberty by the police that are relevant to both Articles 32 and 33 of this Recommendation.

230. The training referred to in paragraph 4 should be provided in consultation with local mental health services and include basic guidance on recognition and management of people suspected of having a mental disorder with regard to the relevant legislation. Attention is drawn to the Council of Europe's package of human rights training materials developed in the *Police and Human Rights 1997-2000* programme<sup>7</sup>.

### **Article 33 – Persons who have been arrested**

231. Different countries have different means of detaining or arresting a person: for example through civil, criminal, or administrative law. This Article does not specify who should have powers of arrest, which is a matter for national law.

<sup>7</sup> available from the Human Rights Information Centre, Council of Europe, F-67075 Strasbourg Cedex, France.

- 232. When a person is arrested, the approach in certain legal systems is that the persons concerned are expected to “speak for themselves” in any interrogation. The purpose of indent i. is to allow a person with mental disorder to be accompanied during the procedure by another person who can provide moral support at this vulnerable time. Certain miscarriages of justice have occurred in which persons with mental disorder have falsely confessed to crimes, and the provision aims to minimise the chance of this happening by decreasing the feeling of vulnerability that the arrested person may have. The provision is therefore an addition, and not a replacement, of any national provisions concerning the right to a lawyer, which the Article does not address.
- 233. As discussed in paragraph 52 above, a personal advocate may be a person close to the individual concerned, or provided by a voluntary body or advocacy service. In these circumstances it is unlikely that there would be any financial implications to the person concerned. If such alternatives are not available to the arrested person, and a person is appointed by the State to fulfil this role, then it is expected that if there is any financial implication to the person concerned it is proportionate to the resources available to that person.
- 234. When a person has been arrested in connection with a criminal offence, it is possible that the presence of a particular personal advocate known to that person at an interrogation might compromise the criminal investigation. For example, that personal advocate might also have been involved in the crime. Alternatively, the advocate might use information given in the interrogation about, for example, the location of stolen goods to remove the goods prior to the police finding them in order to improve the situation of the arrested person.
- 235. Therefore, this Article refers to an “appropriate personal advocate”, who is acceptable both to the person concerned and to the investigating authority. For example, a person from a local voluntary organisation or advocacy body may be able to fulfil the role of personal advocate without the risk of a conflict of interest.

#### **Article 34 – Involvement of the courts**

- 236. Paragraph 1 of this Article makes it possible to apply an involuntary measure even if the person consents to it. Otherwise, it would be possible for an offender to inform the court that he or she consented to a measure. The courts would then take a decision regarding the disposal of the person’s case on that basis; if the offender then immediately refused the measure there would be no power to enforce it, and the appropriateness of the court’s decision on the case could be questionable.
- 237. This Recommendation does not regulate placement and treatment for mental disorder in a criminal justice context in detail. However, the Article emphasises that, in accordance with the guarantees of the European Convention on Human Rights, the person should be able to exercise the right to have the lawfulness of a measure imposed, or its continuing application, reviewed by a court. In addition, the other provisions of Chapter III should be taken into account with regard to placements and treatments imposed by the courts. Any non-application of the provisions of Chapter III should be justifiable; for example, as a result of appropriate security considerations. Non-application merely on grounds of inconvenience would not be justifiable.
- 238. In particular, it should be noted that it is not appropriate for a person to be subject to placement for mental disorder if that placement does not have any therapeutic purpose, or in other words that the purpose is only custodial.
- 239. Imprisonment may be regarded as a form of “involuntary placement”. However, the term “involuntary placement” when used in this Recommendation always refers to involuntary placement on grounds of mental disorder. Similarly, the term “placement” used in this Article refers to placement in relation to mental disorder. Hence it is possible for a person with, for example, a mild mental disorder to receive a normal prison sentence. That person is not subject to “placement” in relation to his or her mental disorder.
- 240. On the other hand, a person with a serious mental disorder might commit a very serious offence such as murder. The court, on the basis of appropriate medical evidence as required by paragraph 2 of this Article, might dispose of the case by making an order for placement in a high security psychiatric facility and for the person to receive involuntary treatment in that facility. In this example the person is subject to both involuntary placement and involuntary treatment within the meaning of this Recommendation.

- 241. The court should determine whether a person has a mental disorder that has diminished their criminal responsibility and if appropriate take this into account. Paragraph 2 of this Article follows Principle 20(3) of the United Nations Resolution A/RES/46/119 concerning *The protection of persons with mental illness and the improvement of mental health care* which requires courts to act on the basis of competent and independent medical advice in making orders concerning placement in a mental health facility.
- 242. People with mental disorders who have offended may be treated in the community, normal prison facilities or psychiatric facilities, both civil and secure (outside prison or in specialised prison facilities subject to Recommendation R (98)7 of the Committee of Ministers to member states *concerning the ethical and organisational aspects of health care in prison* (paragraph 55 of the Appendix thereof)). The indications for treatment in different settings include the severity of the mental disorder and its treatability as well as the nature of the offence.
- 243. In some countries if a person is considered in need of psychiatric assessment it is possible for the person to be sent for in-patient assessment without medical advice being taken by the court – the purpose of the medical assessment is to enable such advice to be given. However, it is considered that an order for assessment prior to a decision being made on the appropriate sentence is not a sentencing decision as such and is therefore not covered by this paragraph.
- 244. It was agreed that paragraph 2 does not exclude the possibility, according to national law, for a court to impose psychiatric assessment or a psychiatric or psychological care programme (including programmes designed to address substance misuse) as an alternative to prison or to the delivery of a final decision.
- 245. Where a person deemed unfit to plead through mental disorder is subject to involuntary placement or involuntary treatment for an unspecified period, in accordance with the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment particular attention needs to be given to regular review of these measures according to the provisions of Article 25 of this Recommendation.

### **Article 35 – Penal institutions**

- 246. This Article applies to prisons, remand institutions and other penal institutions. The Preamble draws attention to the need to have regard to the provisions of R (87)3 on the *European Prison Rules*. Paragraph one of the Article emphasises that persons with mental disorder are entitled to benefit from all the protective provisions of Recommendation R (98)7 *concerning the ethical and organisational aspects of health care in prison* that is highlighted in the Preamble to this Recommendation.
- 247. In particular, attention is drawn to the requirement of paragraph 13 of that Recommendation that “medical confidentiality should be guaranteed and respected with the same rigour as in the population as a whole”.
- 248. The principle of equivalence of care is considered to be fundamental by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and it is also included in Recommendation R (98)7 referred to above. The CPT Standards state that a prison health care service should be able to provide medical treatment and nursing care in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, pharmacy, nursing, and technical staff, as well as premises, installations and equipment should be geared accordingly.
- 249. The CPT also points out that in comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners. Hence, it considers that a doctor qualified in psychiatry should be attached to the health care service of each prison. The Article highlights the importance of appropriate therapeutic options being available to persons with mental disorder detained in penal institutions (“prisoners”). This includes therapeutic programmes for prisoners with personality disorder, although it should not be assumed that all such prisoners either want or can benefit from such programmes.
- 250. In particular, Recommendation R (98)7 *concerning the ethical and organisational aspects of health care in prison* calls for prisoners with serious mental disturbance to be cared for in a hospital unit that is adequately equipped and possesses appropriately trained staff.

- 251. A prisoner (or his/her legal representative) with mental disorder who considers that the care given in a penal institution is inappropriate to his or her condition or who considers that the condition is incompatible with the environment of the penal institution should be able to ask for appropriate care or transfer. If such care or transfer is denied, an appropriate appeal system should be made available.
- 252. When involuntary treatment is administered in a penal institution, there is a significant difference between the situation in which a person submits to the treatment and that in which the person actively resists it. In the former case, treatment can be administered in a suitable medical unit but in the latter case it should only be administered in a hospital unit suitable for the treatment of mental disorder.
- 253. Member states are responsible for deciding whether the hospital unit in a penal institution is suitable for the treatment of mental disorder. In making that decision, consideration should be given to whether it is possible to provide care in accordance with the standards set out in this Recommendation in the unit. Hospital units designated as suitable for the treatment of mental disorder should be registered and monitored by an appropriate national body.
- 254. The use of seclusion or restraint in the context of penal institutions is discussed in paragraphs 203 and 204 above.
- 255. The independent monitoring system referred to in paragraph 4 should be independent of the prison authorities. It may be beneficial to combine that system with that (or those) concerned with quality assurance and monitoring covered by Chapter VII below.

## **Chapter VII – Quality assurance and monitoring**

### **Article 36 – Monitoring of standards**

- 256. Quality assurance and monitoring are important in ensuring the protection of the human rights and dignity of persons with mental disorder, in ensuring the delivery of high quality care for such persons and in ensuring compliance with the relevant legal standards, including those set by this Recommendation. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment Standards specify that the Committee "attach considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body".
- 257. States may have different methods for quality assurance and monitoring. For example, in some States a single body may carry out monitoring of legal, technical and professional standards. In other States one body may be responsible for legal standards and another body for professional and technical standards. The Article does not prescribe a particular approach.
- 258. In respect of paragraph 2.iii. non-governmental organisations involved in the field of mental health and human rights can also play an important role. In particular, organisations involving persons who currently use, or who have previously used, mental health services and those close to such persons (notably persons who act as carers to persons with mental disorder) should be invited to participate.
- 259. In respect of paragraph 2.iv., there should be coordination between the system developed under this Article and the body undertaking the independent monitoring of the treatment and care of persons with mental disorder in penal institutions, as required by Article 35.4 of this Recommendation, if the two are separate entities. There may be benefits in both functions being carried out by the same organisation.

### **Article 37 – Specific requirements for monitoring**

- 260. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has made recommendations about the activities of the body referred to in paragraph 256 above which are included in this Article.
- 261. Some examples of monitoring of professional obligations and standards include ensuring that staff are appropriately qualified for their role; that they are using appropriate clinical protocols; and that use of restraint and seclusion is appropriate. There are many other examples.
- 262. With regard to paragraph 3.iii., it is important that the identity of the person concerned cannot be deduced. This may require particular consideration in relation to small facilities.

#### **Article 38 – Statistics, advice and reporting**

263. Collecting and making available statistical and other relevant information is useful for the purposes of monitoring, identifying good practice and for international comparisons. Audit of selected cases and transparent case-law are important methods for member states to maintain their standards in accordance with the provisions of this Recommendation and other relevant instruments, including the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.
264. It is desirable that each State prepares full and clear statistics on the use of involuntary measures including the number of persons concerned, their diagnostic categories, the duration of the involuntary measures, the number of appeals, the length of proceedings and their outcomes, and the use and locations of facilities for involuntary placement.